National Office of Clinical Audit

# NOCA CONFERENCE 2026

## E-POSTER'S

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# Evaluating direct-acting oral anticoagulant (DOAC) dosing based on calculated Creatinine clearance in patients over 65 with Atrial Fibrillation, admitted to acute medical wards

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**Sponsor**: Dr Ruairi Waters, Department of Geriatrics, Galway University Hospital

## Background

Patients admitted for management of acute illnesses often do not have DOAC doses checked appropriately. NICE guidelines (NG 196) state dose checks should be completed annually, or more frequently if clinically indicated. Guidelines state dose checks should be based on a calculated Creatinine clearance. The aim of this audit was to evaluate how often patients have documented dose checks in line with current guidelines.

## Methods:

- Chosen population of inpatients over 65 with Atrial Fibrillation on DOAC therapy.
- Kardex reviews completed on a sample size of 20 patients.

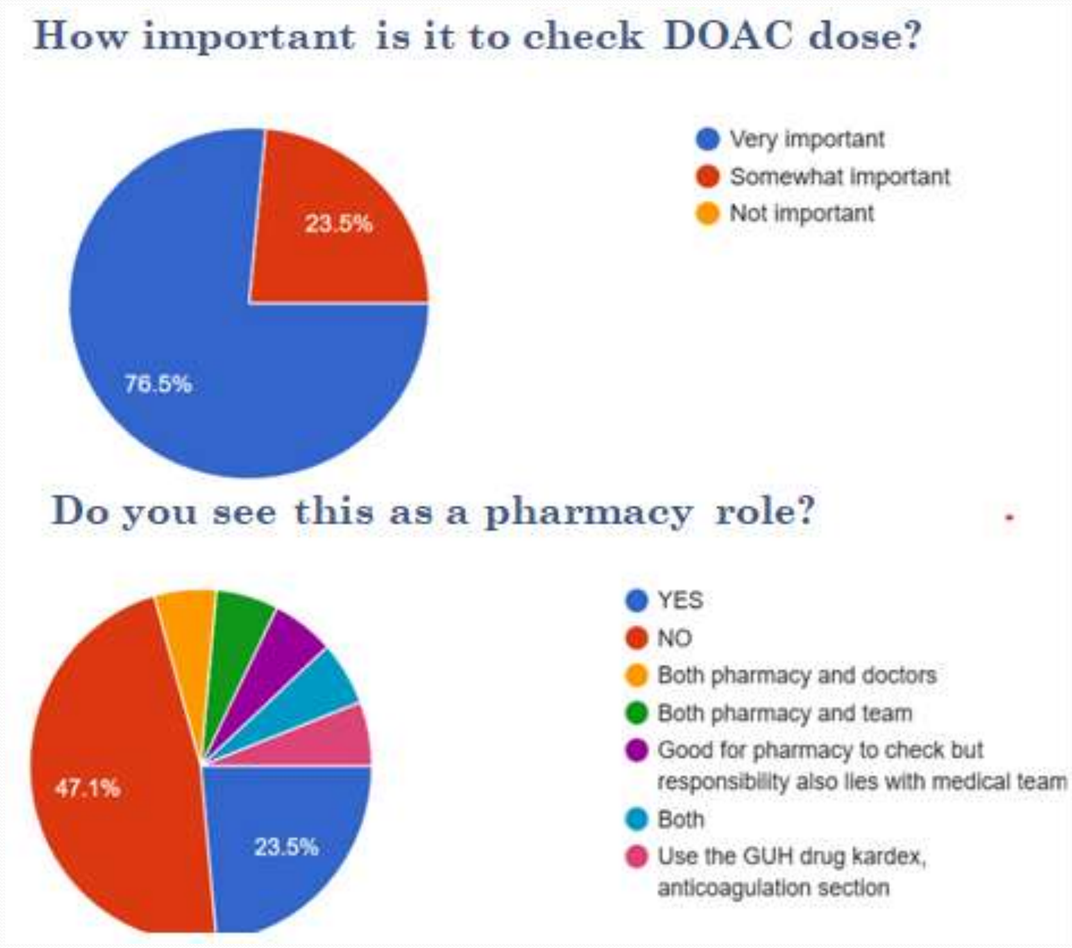
## Objectives

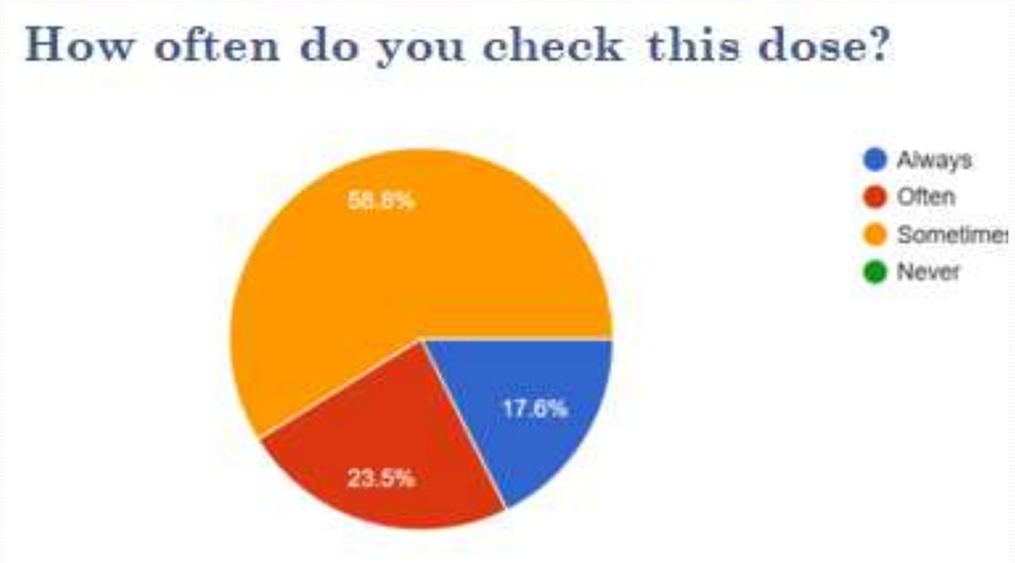
- Promote safe prescribing of DOACs in the older population
- Provide further education to NCHDs regarding DOAC prescribing
- Patient safety promotion

## Key Findings

- Weight and height recording was absent on kardex in 65% of cases.
- eGFR recorded in 90% of cases. CrCL calculation seen in only 15% of cases.
- When dose checks are done, they are being done by pharmacy department first and foremost.
- 10% of patients were missed as those requiring a change to their DOAC.

## NCHD perspectives




## Potential barriers flagged by NCHDs

- Internet connection & PC availability
- Time/Rushing on ward rounds- not often considered a priority task
- Confidence in accurately calculating doses
- Having a ready available calculator
- Not having data recorded- weight/height
- Not knowing what resource to use

## Improvements

- Education sessions completed with incoming NCHD staff starting in GUH
- Presentation at hospital Grand Round meeting to highlight the need for improvement
- Discussion with pharmacy department regarding standardized tool availablity on local hospital resource Medinfo

## Conclusion

- There needs to be an improvement in DOAC dose checking to ensure patient safety.
- The need to highlight to staff, the availability of a standardized tool on hospital specific MedInfo resource to ensure an approved and reliable approach is used to calculate CrCl in all inpatients.
- NCHDs felt more education was beneficial regarding DOAC prescribing in order to improve current findings.

## Resources

- NICE guideline (NG196). Atrial fibrillation: diagnosis and management. Last Updated June 2021.
- Galway University Hospital, MedInfo online resource platform

Medinfo Galway.ie

# A PATIENT INITIATED REVIEW PATHWAY FOR THE MANAGEMENT OF BENIGN PAROXYSMAL POSITIONAL VERTIGO

Donncha Lane, Clinical Specialist Physiotherapist
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## Introduction

Benign Paroxysmal Positional Vertigo (BPPV) is a highly prevalent inner ear/vestibular disorder that can cause dizziness and balance problems in any age group.

The reported recurrence rate of BPPV is 14%-48% for studies with follow-up <1 year, and from 13%-65% for studies with follow-up ⩾2 years (1).

International best practice guidelines recommend that individuals who are treated for BPPV are informed on how to manage potential return of symptoms (2).

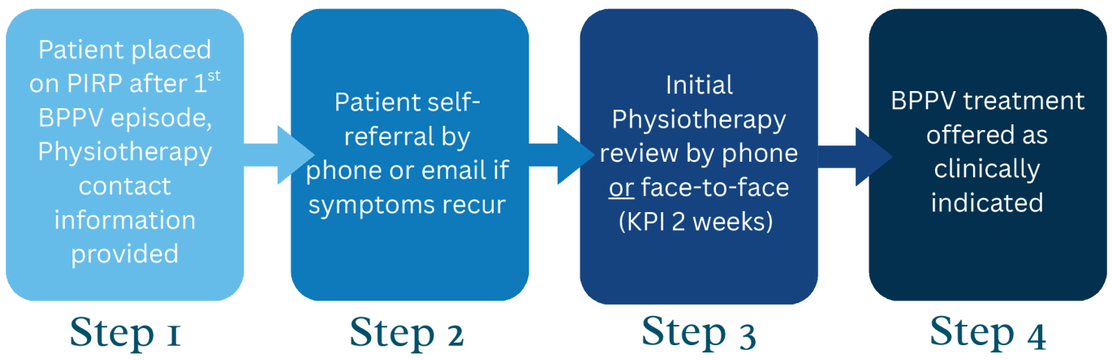
In 2021, a Patient Initiated Review Pathway (PIRP) was established at MMUH. Where BPPV symptoms recur, the PIRP allows self-referral to the Out-Patient (OPD) Vestibular Physiotherapy service, in line with HSE and Sláintecare commitments (3).

## Aim

1. To provide an overview of the demographics and clinical outcomes of individuals who self-referred through the BPPV PIRP in 2024.

2. To ascertain the responsiveness of the PIRP, in line with the locally set Key Performance Indicator (KPI): a review within 2 weeks of patient contact.

Figure 1. PIRP Process




## Results

In 2024, n=38 individuals made contact with the OPD Vestibular Physiotherapy service through the PIRP.

For 70% of individuals, this was the first episode of BPPV recurrence.

The median number of days to the first recurrent episode was 260 days.

n=37 individuals attended for an OPD review, n=1 did not respond to an offer of a review.

Two individuals had two separate recurrent episodes of BPPV in 2024.

**Age**
Median age 64 yrs
Interquartile Range (IQR) 56 yrs - 76 yrs

**Gender**
Female 76%
Male 24%

78% of individuals used the PIRP as their first medical point of contact after the return of symptoms

**Wait-time for OPD Review**
Median 6 days
IQR 5 days - 12 days

**OPD Review within 2 weeks**
Yes 89%
No 11%

**BPPV Diagnosed at OPD Review**
Yes 69%
No 31%

**Number of Physiotherapy OPD Sessions**
Median 2 session
IQR 1 session - 2.5 sessions

**96% of individuals diagnosed with BPPV had full resolution and/or a significant improvement in subjective symptoms within 2 sessions.**

## Conclusion

The PIRP for BPPV is responsive to the needs of the individual, with ~90% reviewed within 2 weeks of contact.

There are potential cost-savings associated with the PIRP through the reduced need for GP and/or Acute Hospital care.

The PIRP represents an efficient use of the OPD Vestibular Physiotherapy service at MMUH in terms of responsiveness and number of sessions required to manage this cohort.

## Next Steps

Consider the implementation of a standardised phone screen for all individuals contacting the service. This could further improve the rate of review in line with the 2 week KPI.

## References

1. Sfakianaki I, Binos P, Karkos P, Dimas GG, Psillas G. Risk Factors for Recurrence of Benign Paroxysmal Positional Vertigo. A Clinical Review. J Clin Med. 2021 Sep 24;10(19):4372. doi: 10.3390/jcm10194372. PMID: 34640391; PMCID: PMC8509726.
2. Bhattacharyya N, Gubbels SP, Schwartz SR, Edlow JA, El-Kashlan H, Fife T, Holmberg JM, Mahoney K, Hollingsworth DB, Roberts R, Seidman MD, Steiner RW, Do BT, Voelker CC, Waguespack RW, Corrigan MD. Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update). Otolaryngol Head Neck Surg. 2017 Mar;156(3_suppl):S1-S47. doi: 10.1177/0194599816689667. PMID: 28248609.
3. https://www.hse.ie/eng/about/who/acute-hospitals-division/pir-national-guidance-document.pdf

CA25-044

# CLINICAL OUTCOMES OF AN ACUTE PATHWAY FOR THE MANAGEMENT OF BENIGN PAROXYSMAL POSITIONAL VERTIGO

DONNCHA LANE
CLINICAL SPECIALIST PHYSIOTHERAPIST
MATER MISERICORDIAE UNIVERSITY HOSPITAL

R25-CA22-067

## 01 INTRODUCTION

Benign Paroxysmal Positional Vertigo (BPPV) is a highly prevalent inner ear/vestibular disorder that can cause dizziness and balance problems in any age group.

International Clinical Practice Guidelines (CPGs) cite 14 Key Action Statements for clinicians in the management of BPPV.

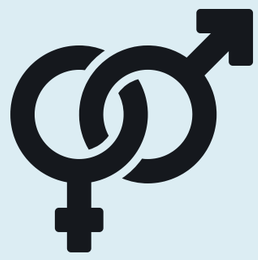
The Key Action Statements encompass best practice recommendations for assessment, differential diagnosis, treatment, medical management, post-treatment advice, follow-up and education of individuals who are diagnosed with BPPV.

## 02 AIM

1. To provide an overview of the demographics and clinical profile of individuals diagnosed with BPPV by Inpatient Physiotherapists from the relevant Acute Care Services (Acute Medicine, Neurology and Stroke services) and subsequently referred to the Outpatient (OPD) Vestibular Physiotherapy service at MMUH in 2024.

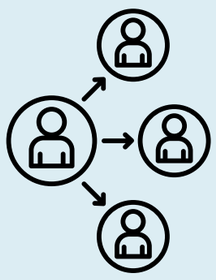
2. To audit the following CPG standards for 2024:
- The use of radiographic diagnostics (CPG Recommendation 3a).
- The use of vestibular suppressant medications (CPG Recommendation 6).
- A re-audit of OPD follow-up times (CPG Recommendation 7a).

## 03 RESULTS
### DEMOGRAPHIC AND CLINICAL PROFILE (N=39 INDIVIDUALS)

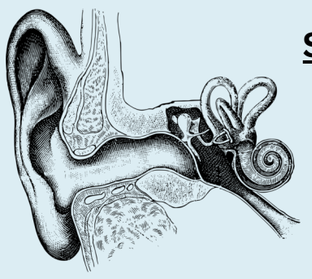


**Gender**
Female 62%
Male 38%

**Age**
Median age 61 yrs
Interquartile Range (IQR)
51 yrs - 73 yrs



**Inpatient Referral Source**
Acute Medicine 70%
Neurology 22%
Stroke 3%
Other 5%



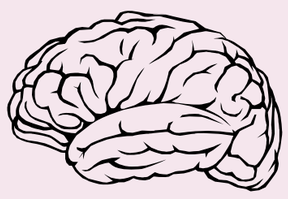
**Semi-Circular Canal Affected**
Posterior canal 75%
Horizontal canal 15%
Anterior 0%
Other - 'query BPPV' 10%

**BPPV Resolved at OPD Follow-Up**
Yes 69%
No 31%

**Increased Risk of Falling after BPPV Resolved**
Yes 20%
No 80%

**Number of Physiotherapy OPD Sessions**
Median 1 session
IQR 1 session - 2 sessions

## 04 RESULTS
### CPG STANDARDS



3a. Radiographic testing — Clinicians should *not* obtain radiographic imaging in a patient who meets diagnostic criteria for BPPV in the absence of additional signs and/or symptoms inconsistent with BPPV that warrant imaging.

**Brain Imaging Completed during Acute Care**
Yes 87%
No 13%

6. Medical therapy — Clinicians should *not* routinely treat BPPV with vestibular suppressant medications such as antihistamines and/or benzodiazepines.

**Vestibular Suppressants Prescribed Acutely**
Yes 53%
No 47%

**Continued Use of Vestibular Suppressants at OPD Review**
Yes 16%
No 73%
Medications not known 11%

7a. Outcome assessment — Clinicians should reassess patients within 1 month after an initial period of observation or treatment to document resolution or persistence of symptoms.

**OPD Review within 1 month**
Yes 89%
No 11%

**Wait-time for OPD Review**
Median 18 days
IQR 12 days - 21 days

## 05 CONCLUSION

1. The demographics and clinical profile of BPPV cases referred through the MMUH pathway is in line with global trends for this prevalent vestibular disorder.

2. ~90% of individuals were reviewed within 1 month of acute treatment, in line with CPG Standard 7a (in comparison to 97% in 2022).

3. Nearly one third of individuals referred through this pathway required further OPD treatment for BPPV after the acute inpatient episode of care was finished.

4. The use of medical therapy and radiographic testing appears to be in excess of that recommended by the CPG, and further exploration of this is warranted.

ACKNOWLEDGEMENTS

Thanks to all the Inpatient Physiotherapists and Medical Physicians on the Acute Medicine, Stroke and Neurology teams.

# An audit of Evaluation of stroke patients having an ECG carried out after their admission in stroke Unit in Our Lady of Lourdes Hospital Drogheda.

Jawed, Muhammad Yousha.

## Background

Electrocardiography (ECG) plays a pivotal role in identifying atrial fibrillation (AF), a prevalent arrhythmia that significantly contributes to stroke risk. AF increases the likelihood of stroke by 3 to 5 times and is responsible for approximately 15% to 30% of all acute ischemic strokes. The prevalence of AF rises with age, with studies indicating that up to 40% of individuals aged 90 and above may be affected. Notably, stroke patients with AF experience higher mortality and morbidity rates compared to those without AF. For instance, a study from the Irish Medical Journal revealed that the death rate among stroke patients with AF was 11%, compared to 5.7% in those without AF. Furthermore, AF-related strokes often result in more severe outcomes, including greater disability and longer hospital stays. Given these significant implications, early detection of AF through ECG is crucial for implementing timely interventions that can substantially reduce stroke risk and improve patient outcomes.

## Standard

*National clinical guideline's for stroke 2023 . https://www.hse.ie/eng/about/who/cspd/ncps/stroke/resources/national-clinical-guideline-for-stroke.pdf*

## Methods

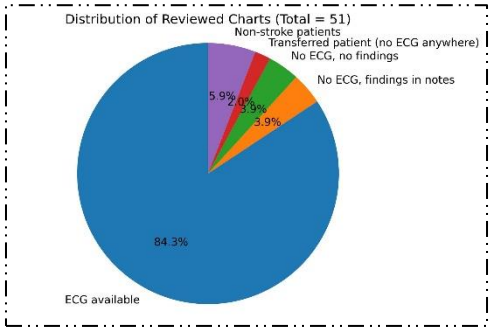
✓ Retrospective chart reviews in oriel2 admissions for the proceeding one month.

## Findings

- Total number of charts reviewed are 51.
- Out of which charts having ECG are 43.
- Charts not having ECG, even though findings are mentioned in medical notes are 2.
- Charts neither having ECG nor having any findings mentioned in medical notes are 2.
- Charts for patients who transfer from other hospital but neither they have ECG attached with transfer letter nor any finding mention in transfer letter as well as no ECG in OLOL Drogheda is 1
- Charts for patient who are non-stroke are 3.

## Conclusions

- 84% of Stroke patients have ECG in their charts.
- 4% of stroke patients do not have ECG in their chart even though findings are mentioned in the chart.
- 4 % of stroke patients neither have ECG nor findings are mentioned in the chart.
- 2 % of stroke patients are those who are transferred from other hospital but neither ECG nor ECG findings are mentioned in the transfer letter as well as the patient did not have ECG in OLOL.
- 6% of patients are non-stroke

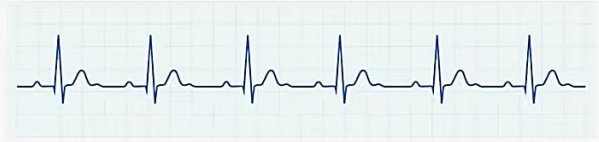



## Recommendations

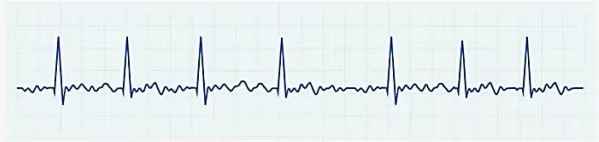
✓ · **Education and Training:** Educate clinical staff (nurses, junior doctors) on the importance of performing ECGs for stroke patients, especially those at high risk for arrhythmias.

· **Reminder Systems:**

- Implement reminder systems (e.g., checklist in the admission process or electronic alerts) to prompt healthcare providers to order an ECG.



Normal ECG



Atrial fibrillation

# National audit of pre-gestational diabetes care in 2023: scope for further optimisation

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[2]College of Medicine, Nursing and Health Sciences, University of Galway, Ireland
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## INTRODUCTION

Pre-gestational diabetes (PGDM) confers increased risk for adverse pregnancy outcome. In particular, stillbirth and congenital anomaly are relatively increased in pregnancies affected by maternal type 2 diabetes (T2D).

Since 2015, our national audits have highlighted suboptimal preparation in the majority of women with T2D and emphasised the importance of good glycaemic control, pre-pregnancy folic acid use and dedicated pre-pregnancy clinics.

## AIMS

- Evaluate pre-pregnancy preparedness in women with T2D with pregnancy in 2023
- Describe pregnancy and neonatal outcomes in these women
- Discuss potential areas for improvement in care for women with T2D

## METHODS

**Study design:**
Electronic data was collected by participating maternity units with support from the National Diabetes in Pregnancy audit group and National Perinatal Epidemiology Centre (NPEC) on the RedCap platform. 15 maternity hospitals contributed data at the time of data analysis.

**Population:** Women diagnosed with T2D prior to or in early pregnancy during 2023

**Variables analysed:**
Maternal: BMI, ethnicity, pre-pregnancy care, assisted fertility use, medication use, HbA1c, gestational weight gain, delivery
Neonatal: birth centile, neonatal hypoglycaemia (NH), congenital anomaly, special care baby unit (SCBU admission), stillbirth

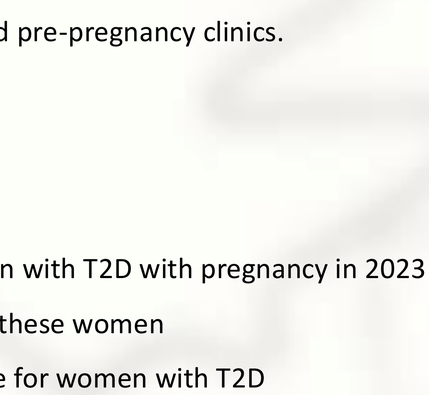
**Statistics:** Statistical analysis was performed on Microsoft Excel

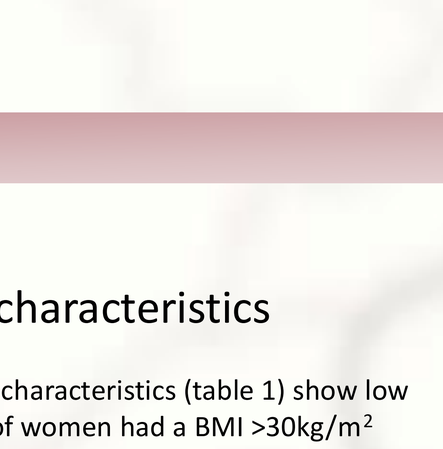
## RESULTS

### 1. Maternal and pregnancy characteristics

Data were available on 153 women with T2D. Maternal characteristics (table 1) show low levels of pre-pregnancy care and use of folic acid. 70% of women had a BMI >30kg/m$^2$ and over 50% of women were non-white (figure 1).

| Maternal characteristics | |
|---|---|
| Mean age (years) | 34.9 ± 4.7 |
| Mean BMI (kg/m$^2$) | 34.3 ± 7.3 |
| Mean gravidity | 2.7 |
| Mean parity | 1.2 |
| Retinopathy | 14 (9.2%) |
| Pre-pregnancy care | 12 (7.8%) |
| Fertility treatment | 10 (6.5%) |
| 5mg folic acid usage | 54 (35.3%) |
| Teratogenic medication use | 8 (5.2%) |
| Pre-pregnancy HbA1c (mmol/mol) | 51 ± 28 |
| Trimester 1 HbA1c (mmol/mol) | 51 ± 14 |
| Trimester 3 HbA1c (mmol/mol) | 41 ± 8 |
| Gestational weight gain (kg) | 7.9 ± 6.6 |

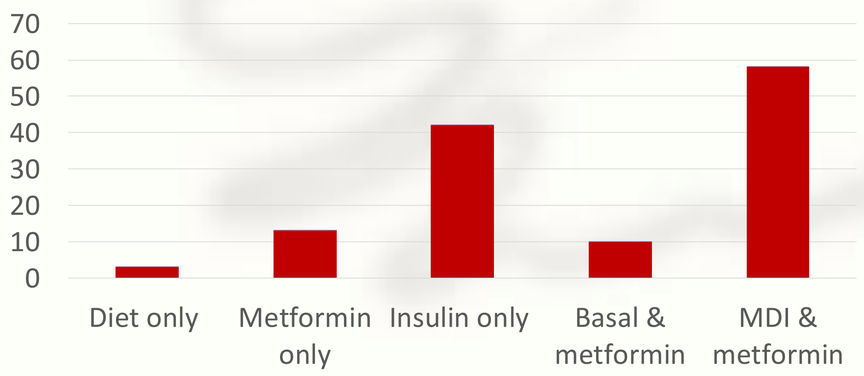



Details of treatment were available for 130 women. 81 women (62%) received metformin of whom the majority (84%) required the addition of insulin (figure 2). 42 (32%) received insulin alone.

Pre-pregnancy use of GLP1RA and SGLT2i were recorded in few cases.

Figure 2: Glycaemic Treatment in Pregnancy




### 2. Delivery and neonatal outcomes

- Live birth rate 84%
  - 1 stillbirth
  - 23 miscarriages
- Delivery modality (n=115):
  - Spontaneous vaginal delivery = 23%
  - Assisted = 4 (3.5%)
  - Caesarean section = 80 (70%)
    - 38% Emergent (NICE category 1-2), 62% elective (NICE category 3-4)

| Neonatal characteristics | |
|---|---|
| Birthweight | 3.22 ± 0.61kg |
| Gestation at delivery | 37 ± 3weeks |
| LGA | 19 (15%) |
| SGA | 8 (6.2%) |
| Congenital anomaly | 3 (2.3%) |
| SCBU admission | 25 (19%) |
| Neonatal hypoglycaemia | 12 (9.3%) |

## DISCUSSION

There was increased ethnic diversity in women with T2D in 2023 compared to previous audit years. Baseline BMI increased longitudinally during audit follow up; 55% had BMI >30kg/m$^2$ in 2015-2020 data compared to 70% in 2023. Pre-pregnancy use of GLP1RA was noted in very few cases however may become more commonplace in the future.

Rising rate of Caesarean section compared to 59% in previous audit years in this population is striking and predominantly driven by increased elective section.

The rate of congenital anomaly was lower in 2023 relative to 5.1% in previous audit years despite similar pre and early pregnancy HbA1c but lower rate of teratogenic medication use.

Newman C et al. Retrospective national cohort study of pregnancy outcomes for women with type 1 and type 2 diabetes mellitus in Republic of Ireland. Diabetes Res Clin Pract. 2022

Contact details: Mairéad Crowley, MB BCh BAO MRCPI Fellow in Diabetes in Pregnancy, University College hospital Galway. Email: mairead.crowley5@hse.ie

# Reducing Radiology Diagnostic Delays in an Older Persons Day Hospital: A QI Audit

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[2]St. Ita's Community Hospital, Limerick, Ireland
[3] Ageing Research Centre, University of Limerick
[4]St Camillus Hospital, Limerick, Ireland

## Background

This clinical audit was undertaken to assess the effectiveness of the ICPOP pathway in improving the timeliness of outpatient radiology scans. Most patients reviewed in our Geriatrics outpatient clinic have not had outpatient scans completed within clinically recommended timeframes. This results in delays in diagnosis and management, and places an additional administrative burden on staff scheduling clinic appointments around expected scan completion dates.

The aim of this QI audit was to evaluate outpatient radiology waiting times following the introduction of the ICPOP private radiology pathway in 2024 and to determine whether this intervention has improved scan completion rates.

## Results

A total of 61 outpatient scans booked between 2017 and 2024 were reviewed utilizing the NIMIS RIS system. At the time of audit, approximately 26% (16/61) of scans had been completed. Of these completed scans, ten were arranged privately via the ICPOP booking pathway. Only two scans were completed through standard outpatient radiology slots in UHL. Of these, one scan was performed within the clinically recommended timeframe of three months. This represents a 16% increase in overall scan completion compared to the previous year, where only 5% (3/61) had been completed within the same cohort via UHL.

## Discussion

Overall, the findings suggest that redirecting outpatient scans through ICPOP and utilising private radiology services has improved the total number of scans completed. However, timely completion within recommended clinical timeframes remains limited. Further re-audit is recommended to continue evaluating the effectiveness of this pathway and its impact on reducing outpatient radiology waiting times.

**References**

1. National Treatment Purchase Fund. (2024). *National radiology diagnostic waiting list management protocol* (Waiting List Management Protocol). https://www.ntpf.ie/app/uploads/2024/10/Radiology-Diagnositc-WL-Protocol-Digital.pdf

# From Audit to Action: Reducing the Risk of Healthcare Associated Infections by Ensuring Completion of Monthly Infection, Prevention & Control Audits and Development of an IPC Monthly Message Communication Tool across Older Person Residential Services, HSE Mid West.

Ruth Brennan, Geraldine Crowley, Bushra Farah, Joanne Minogue, Aileen Prout and Trudy Ryan
Healthcare Audit Lead & IPC AMS Team HSE Mid West Quality, Safety and Service Improvement

## INTRODUCTION

In 2023–2024, the HSE National IPC Community Team developed a standardised suite of IPC audit tools for community services. Building on this initiative, the IPC Team established a structured monthly audit schedule which was endorsed by the Directors of Nursing and IPC Link Practitioners across the nine HSE Mid West Older Persons Residential Services (OPRS). By achieving 100% compliance with audit completion this provided data required for analysis. To strengthen assurance and support best practice, the IPC Team analysed the data and created a communication tool to share key learning and drive continuous improvement both locally and regionally.

## AIM

Conduct monthly Infection Prevention and Control (IPC) audits for HSE Mid West Older Persons Residential Services using the Healthcare Audit System to assess completion and compliance with National IPC standards and guidelines, identify opportunities for quality improvement, and inform the development of an IPC Monthly Message Communication Tool.

## METHODOLOGY

To ensure consistent implementation, the IPC HSE Mid West Team conducted a monthly review of audit completion across all nine sites: sample size per location 100%. Where audits are not completed as scheduled, targeted support was provided to facilitate 100% compliance. Following completion of the monthly audits the IPC Team, undertook a detailed analysis of the data. The analysis informed the development of an IPC Monthly Message tailored to Older Persons Residential Services, highlighting key trends and areas for improvement. To ensure consistency and clarity in communication, a standardised infographic template was developed for the IPC Monthly Message. A survey was undertaken to assess the overall value of the project with the aim of informing decisions regarding continuation of the project into 2026.

The National Quality and Patient Safety Directorate Quality Improvement Guide and Toolkit (2024) was used to guide this project. The HSE Visual Identity Guidelines (2022) were used to inform the layout of the IPC Monthly Message.

## RESULTS

**Completion Rate:** With the support from the IPC AMS Team in 2025 all nine HSE Mid-West Older Persons Residential Sites increased their compliance in completing their monthly IPC audits from an average of 80% to 100%.
**Monthly Message:** A total of twelve monthly messages were devised in 2025. Each month had a different theme to reflect the findings for local and regional learning and quality improvement.
**Survey Feedback:** In Q4 2025, a staff survey was undertaken to obtain feedback and assess engagement, usability of the audit tools and perceived improvements in IPC practices. The survey comprised of five targeted questions utilising a rating scale to evaluate staff perspectives on the communication tool. The response rate was low however the survey endorsed and supported the continuation of the audit schedule in Older Person Services and the IPC Monthly Message as a quality improvement project for 2026.

### Monthly Message Communication Tool Example


### Staff Survey

1 – Strongly Disagree | 2 – Disagree | 3 – Neutral | 4 – Agree | 5 – Strongly Agree

| Statement | Rating (1–5) |
|---|---|
| 1. The IPC audit tools are user-friendly and easy to navigate. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| 2. I am aware of the IPC Monthly Message Communication Tool. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| 3. I regularly discuss the IPC Monthly Message Communication Tool with colleagues. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| 4. I have observed improvements in IPC practice since the introduction of the IPC Monthly Message Communication Tool. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| 5. I would like to see the IPC Monthly Message Communication Tool continued in 2026. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

## CONCLUSION AND NEXT STEPS

The IPC Monthly Message Communication Tool has proven to be a valuable tool in highlighting both strengths and areas for improvement in Infection Prevention and Control (IPC) practices. By identifying patterns of low compliance, it enables the delivery of targeted education and training interventions, ensuring that support is tailored to the specific needs of each area. This targeted approach not only enhances compliance but also fosters a culture of continuous improvement in IPC standards, with the aim to reduce and prevent healthcare associated infections.

This quality improvement project was implemented over a one-year period. To evaluate its effectiveness and impact, a re-audit of each monthly IPC audit will be conducted in 2026. The next Plan Do Study Act (PDSA) cycle is to implement the quality improvement project in the Mid West Mental Health Services.

# Evaluation of a Specialist Geriatric in-patient Service In a Model 3 Hospital

Midland Regional Hospital Tullamore

Authors: Alice Farrelly ANP; Mary Berry CNS Falls /Frailty; Marian Bracken CNS Dementia; Diane O'Toole CNS Older Persons;

## Background

- In Ireland, the population aged over 65 years is projected to be 1.6 million by 2050
- In the HSE, the National Clinical Care Programme for Older People (NCPOP) set out recommendations in the "Specialist Geriatric Services Model of Care (2012)" for acute hospitals
- 2025 marks the midway point of the UN and WHO "Decade of Healthy Ageing 2021-2030"

## Aims

To measure how our service complies with the NCPOP recommendations:

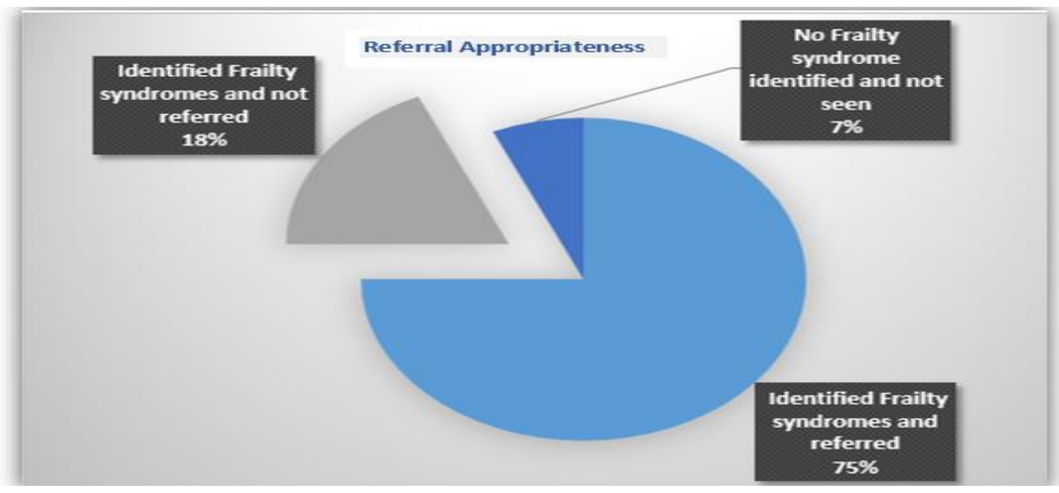
- Pathways in ED to determine Frailty, Delirium and Falls
- All older people identified as frail to have a timely CGA
- CGA is accessible to both primary and secondary teams
- Each hospital to have a specialist geriatric ward(SGW)

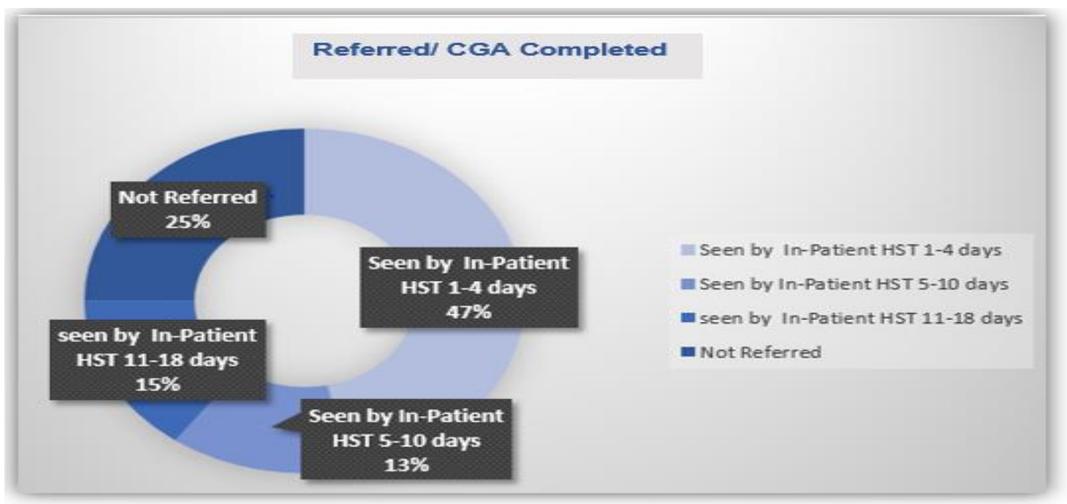

## Methods

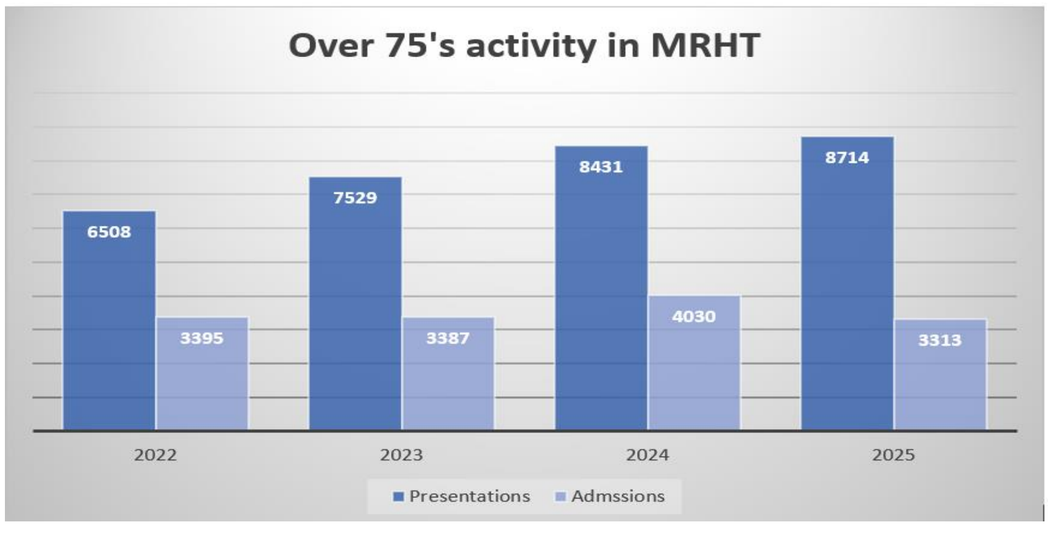
- Using PDSA Cycles and Process mapping, 60 Charts were reviewed of patients over 75 admitted in a 14 day period in January 2025
- Activity analysis exercise of patients over 75 admitted to MRHT over 7 day period to determine the need for a SGW or cohorting

## Findings

- No formal pathway for Frailty or Falls exists after patients are screened using VIP /ISAR in ED
- Patients are seen by Hospital Specialist Team (HST) on request
- 93% (n=56) of patients had one or more frailty syndromes
- 75% (n=45) had CGA's completed within the recommended time frame
- 25% (n=15) were not referred
- 18% of patients with a Frailty syndrome (n=8) were not seen
- CGA is a "hospital only" document
- No SGW is available




## Recommendations

- To formalise pathways for Frailty and Falls
- Continued audit Delirium pathway
- Explore the use of Clinical Frailty Scale in ED as a screening tool
- Discuss the idea of a SGW or cohorting with relevant stakeholders
- In the absence of a Specialist Geriatric Ward the HST are currently exploring strategies to roll out the age attuned care initiatives aligned to the 4M's Age Friendly Care Systems.
- Future digitalisation of CGA


References:
https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/comprehensive-geriatric-assessment-document-.pdf
NCPOP (2012) Specialist Geriatric Services model of care; RCPI & HSE
Learning report Sheffield Trust (2013) Improving Patient flow NHS
WHO (2024) https://www.who.int/news-room/fact-sheets/detail/ageing-and-health#

# "Safer Care Through Smarter Communication: Transforming Patient Education in Regional Anaesthesia"

*Shourya Neema; Prof. Brian Kinirons*
*Department of Anaesthesiology and Critical Care, Galway University Hospital, Galway, Ireland*

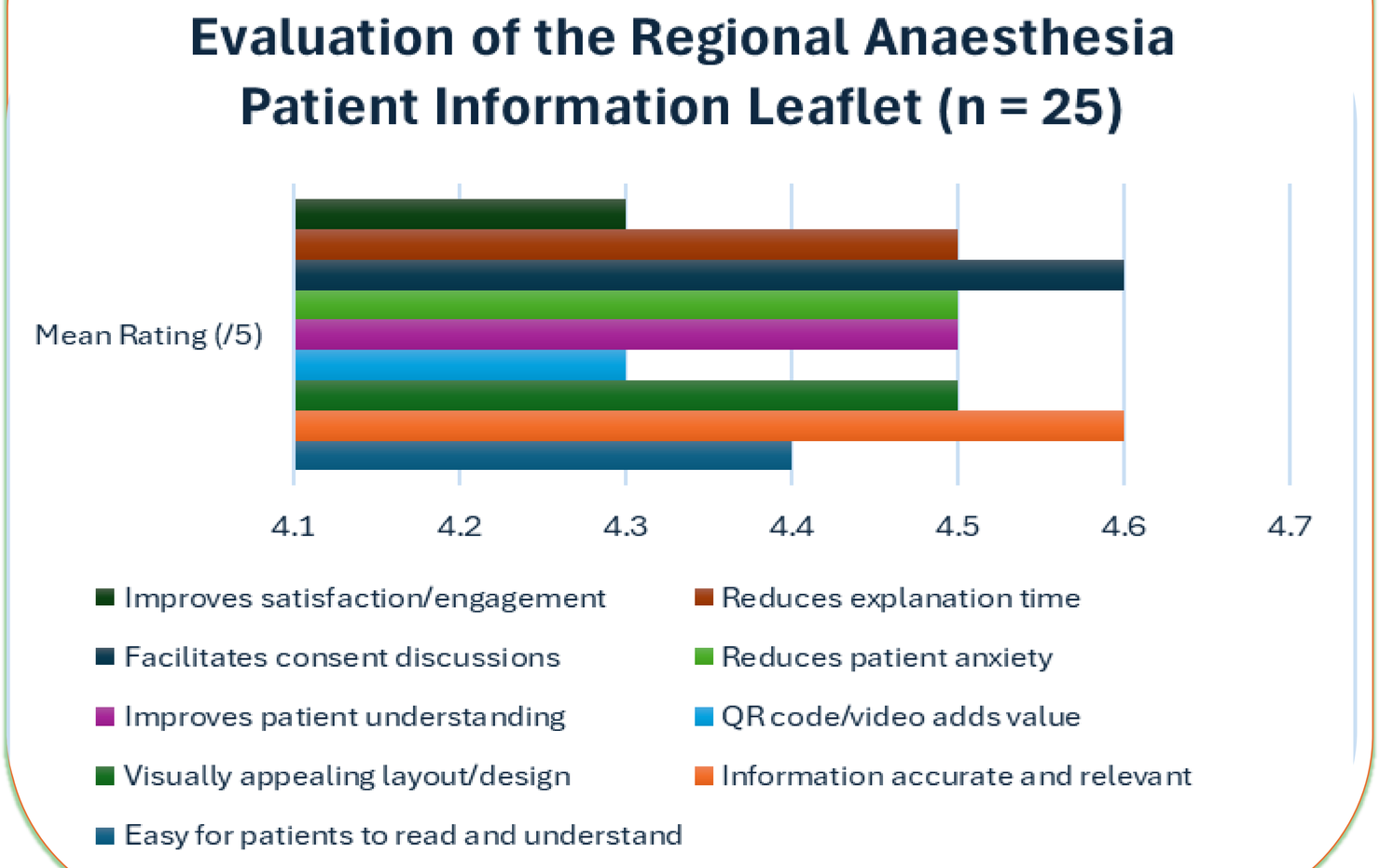
## INTRODUCTION:

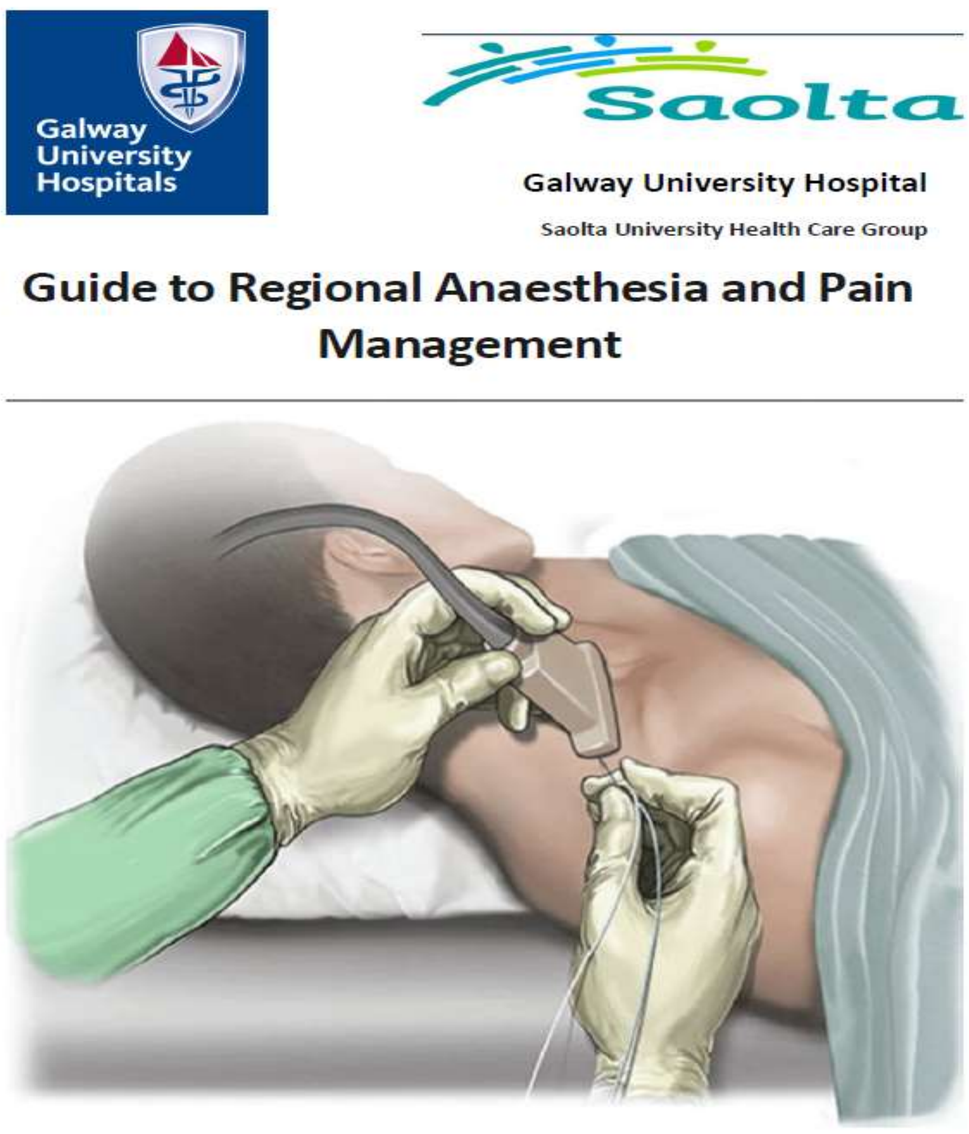
Regional anaesthesia (RA) is widely used in perioperative care, offering targeted pain relief and faster recovery. However, patient understanding of risks, benefits, and aftercare is often limited, contributing to anxiety, suboptimal consent, and post-procedure complications. At Galway University Hospital, a quality improvement (QI) project was initiated to standardise patient education through the development of a RA information leaflet.

## METHOD:

A patient information leaflet on regional anaesthesia was developed at Galway University Hospital to enhance patient understanding and consent. The content was reviewed by anaesthetic consultants, incorporated a QR-linked educational video, and piloted in the block bay. Feedback from staff and patients informed revisions, and the leaflet was finalised for national adaptation across Irish hospitals.

## RESULTS:




**Would you like to implement this leaflet at your institution?**

*Scan this QR code to access the template version of the leaflet.*

If your department would like to adapt it, **please feel free to contact me** — I can update the leaflet according to your institutional requirements.

# Rectus Sheath Catheter (RSC) vs Non-RSC in Postoperative Pain Management

*Shourya Neema; Joanna Fahey, Colm Keane, MD FCAI JFICMI*
*Department of Anaesthesiology and Critical Care, Mayo University Hospital, Castlebar, Mayo, Ireland*

## INTRODUCTION

Postoperative pain after laparotomy remains a major challenge. Opioids, though widely used, cause side effects such as respiratory depression, nausea, constipation, and delayed recovery. The **Rectus Sheath Catheter (RSC)** offers a targeted alternative by delivering local anaesthetic directly to the surgical site. This technique improves pain control, reduces opioid use, supports better breathing, and enhances recovery. RSC is increasingly recognized as a valuable component of multimodal analgesia within ERAS protocols.

## Aim of the Investigation

The primary aim of this study was to compare postoperative outcomes in patients managed with **Rectus Sheath Catheter (RSC)** versus those without RSC following laparotomy surgeries.

**Specifically, we aimed to:**

- Evaluate differences in **pain scores** (numerical rating scale 0–10).
- Compare **opioid and analgesic requirements** between groups.
- Assess the impact on **recovery milestones**, including mobilization time and length of hospital stay

## Method

**Study Design:** Comparative analysis of an updated dataset (N=25 patients).
**Groups:** Patients undergoing laparotomy were divided into:

**RSC Group:** Received continuous local anaesthetic infusion via rectus sheath catheter.
**Non-RSC Group:** Managed without RSC, using conventional systemic analgesia.

- Pain scores at 5 time points (4h–72h)

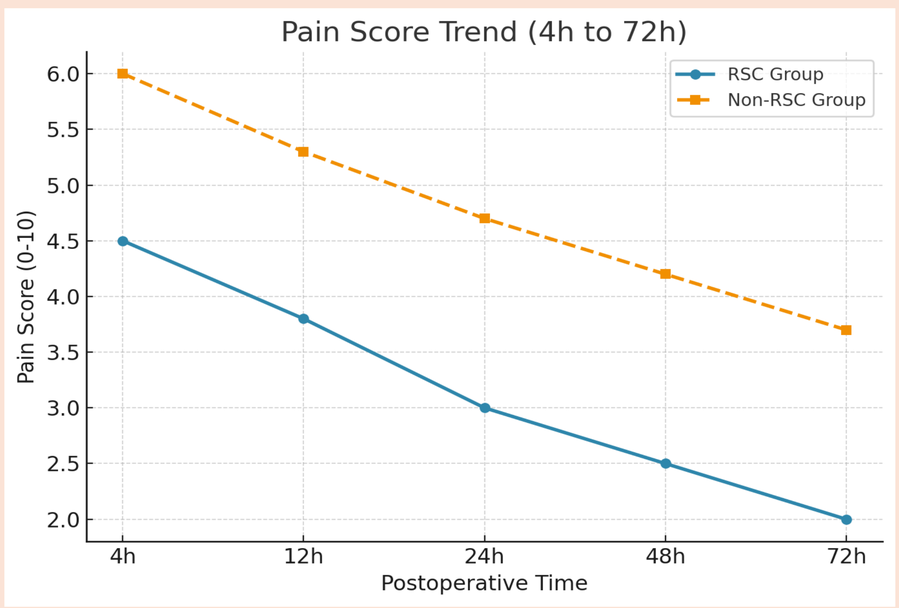
- Morphine usage

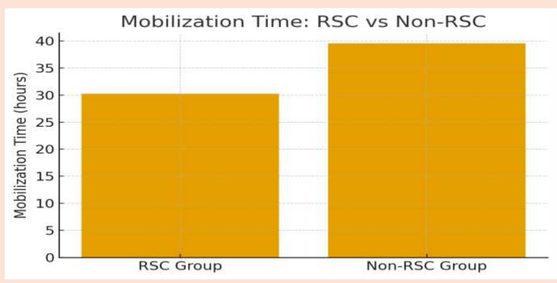

- Rescue analgesia in PACU

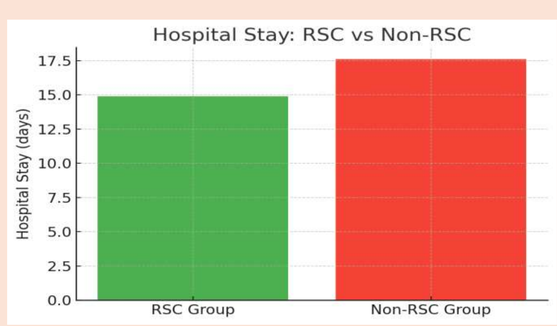

- Mobilization time & Hospital stay

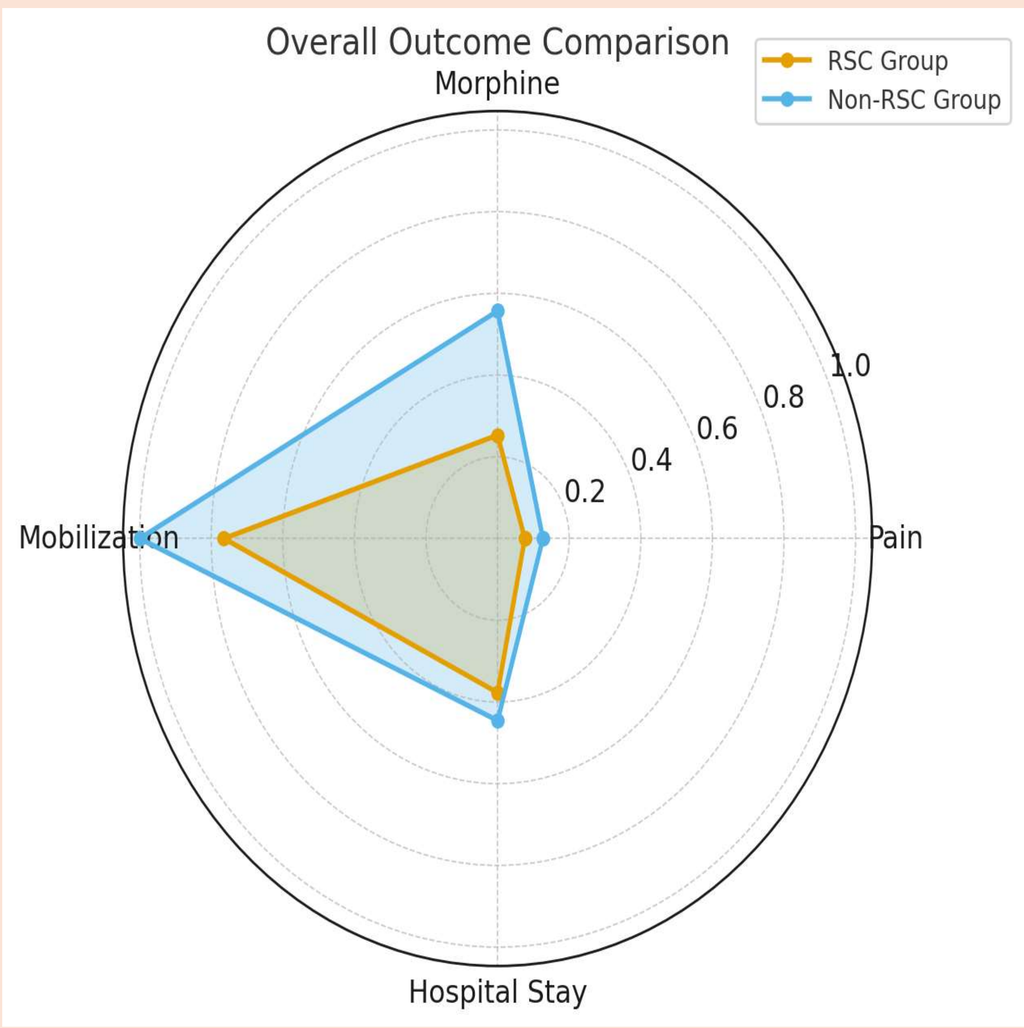
## Results

**Pain:** RSC patients had lower pain scores.
**Opioids:** Less morphine and analgesic use in RSC group.
**Mobilization:** RSC 30.2 hrs vs Non-RSC 39.5 hrs.
**Hospital Stay:** RSC 14.9 days vs Non-RSC 17.6 days.




## Discussion

- RSCs give effective pain relief and reduce opioid use.
- Associated with earlier mobilization and shorter hospital stay.
- Improve patient outcomes and optimize hospital resources.

## Notable Observations

**Three patients in the Audit required NO postoperative PCA morphine at all**, receiving effective pain control with **rectus sheath catheters (RSC)** in combination with **multimodal analgesia.**

### Reference

*Rectus sheath catheters for continuous local anaesthetic analgesia after midline laparotomy: A systematic review and meta-analysis.*
*British Journal of Anaesthesia.* 2020; 125(5): 782–794.

# POSTPARTUM HAEMORRHAGE RE-AUDIT 2025 AT GALWAY UNIVERSITY HOSPITAL: PROGRESS IN CLINICAL GOVERNANCE AND MATERNAL SAFETY

Authors: Patriks Aldersons[1], Pauline Tarpey[1], Tom O'Gorman[1]

Affiliation: [1]Maternity Department, Galway University Hospital, Galway, Ireland

## BACKGROUND

Postpartum haemorrhage (PPH) remains the second leading cause of direct maternal mortality in Ireland and a major contributor to severe maternal morbidity. A 2024 audit at Galway University Hospital identified gaps in documentation, blood loss measurement, and follow-up care. This re-audit in 2025 aimed to evaluate improvements.

## AIM

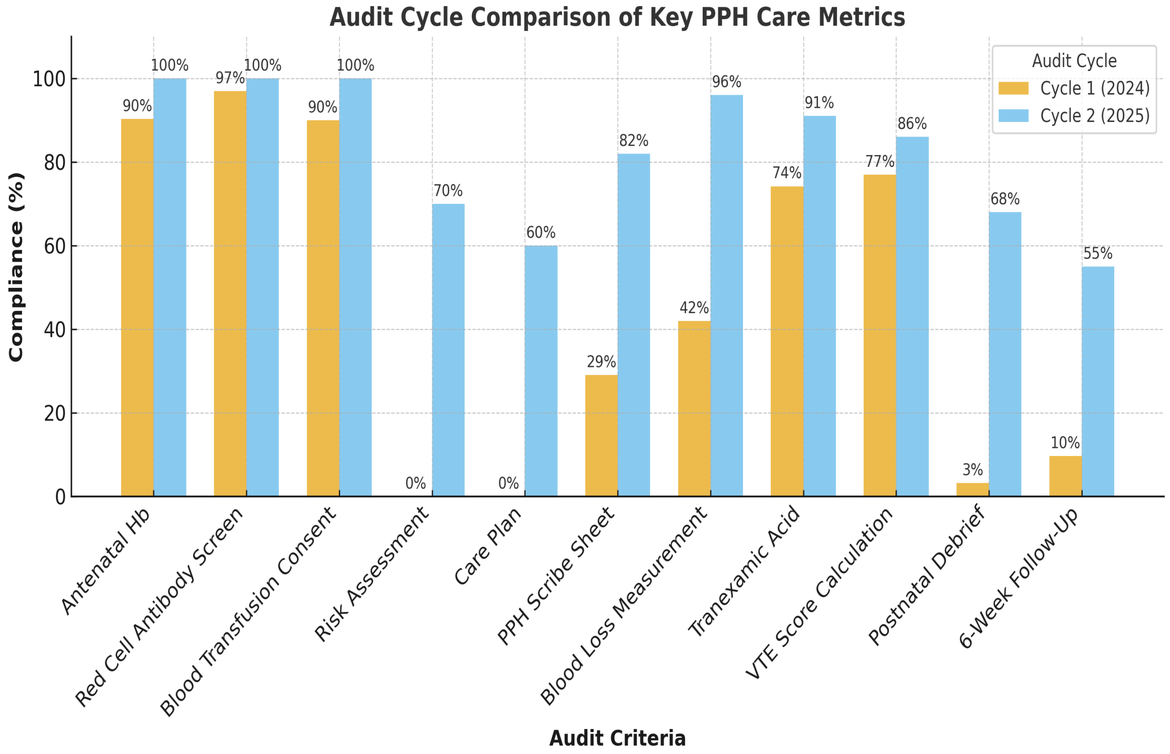
To assess compliance with the National Clinical Practice Guideline on PPH (2022) and measure progress compared with 2024 findings.

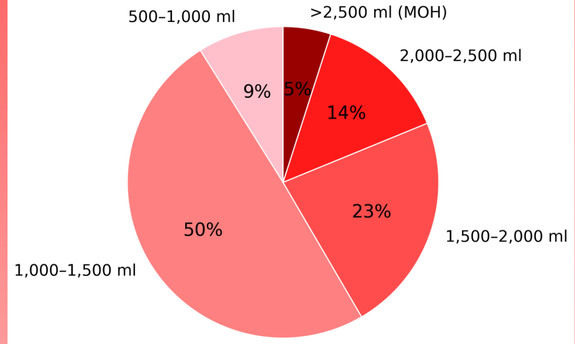
## METHODS

A retrospective review of 22 women with PPH between January and May 2025 was conducted. Cases were identified from electronic records, and data were collected using the HSE National Clinical Care Audit Tool. Patient charts were reviewed against national standards for prevention, recognition, and management of PPH.

## RESULTS

Documentation of risk assessment improved from 0% to 70%, and care planning from 0% to 60%. Use of PPH scribe sheets rose from 29% to 82%, and blood loss measurement from 42% to 96%. Tranexamic acid administration increased from 74.2% to 91%. Postnatal debriefing improved from 3.2% to 68%, and consultant-led 6-week follow-up from 9.7% to 55%. Venous thromboembolism (VTE) scoring improved to 86%, but was not universally completed.

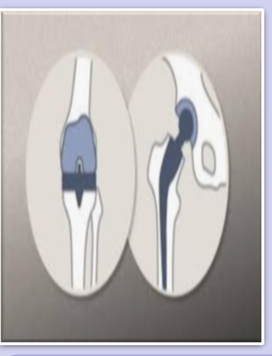



## CONCLUSION

The 2025 re-audit demonstrates significant progress in PPH care, reflecting strengthened clinical governance, documentation, and multidisciplinary response. However, universal implementation of risk assessment, structured care planning, and postnatal follow-up remain priorities. Findings support the role of continuous audit cycles in embedding guideline recommendations and can inform practice in other maternity services aiming to improve maternal safety.

Reference: 1. National Clinical Practice Guideline Postpartum Haemorrhage (NCPGPPH) 2022



# An Audit of the effectiveness of revised analgesia protocol for elective knee/hip joint arthroplasty surgery in a Model 3 hospital.

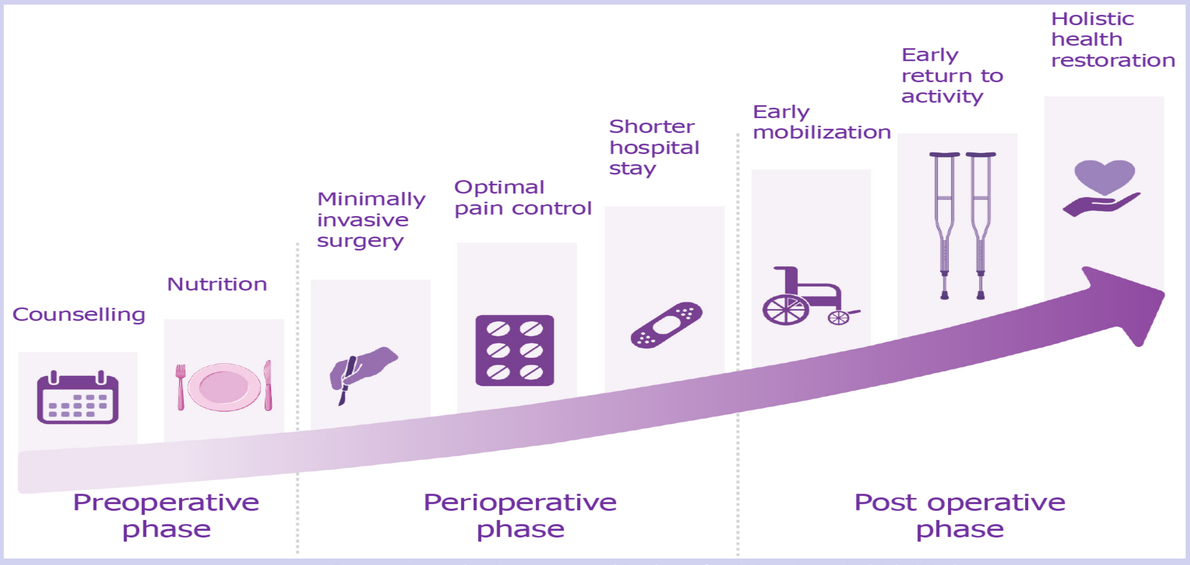
Joanna Fahey CNS Pain, Mayo University Hospital, Ms Rachel O'Neill, Anaesthetic Register Mayo University Hospital, Ms Larisa Di Lucia, School of Medicine, NUI Galway, Ms Bridget Hughes, Consultant Orthopaedic Surgeon, Ms Michelle Duggan, Consultant Anaesthetist Mayo University Hospital.

## Background and Objectives

Effective Postoperative analgesia is critical to enhance recovery, improve patient satisfaction and reduce complication following elective hip and knee arthroplasty. In 2024, a revised multimodal analgesia protocol was introduced in a Model 3 hospital with the aim of optimising pain control, improving patients outcomes and reduced length of stay.

Fast Track or enhanced recovery after surgery (ERAS) for total hip and total knee arthroplasties has evolved over the last 25 years[1]. It was initially introduced to allow a faster functional recovery without an increase in morbidity and mortality as well as to reduce hospital length of stay[2]. Fast Track protocols also improve patient satisfaction and experience and reduce financial burden on the healthcare system[3].

## Fast Track regime




Pre-emptive analgesia: paracetamol 2g, ibuprofen 400mg, isotonic drink 400ml
Anaesthesia: neuraxial only; avoid opioids/benzodiazepines.
Avoid surgical drains
Opioids( oxycodone 5-10mg PO) in recovery only

## Method and Approach

All patients presenting for elective hip or knee arthroplasty were invited to take part in our audit. Ethical approval was obtained from the research and ethics committee at Mayo University Hospital.

This audit monitored patient satisfaction and recovery, as well as length of hospital stay, pain levels over the first 48 hours and time to first mobilisation. This was followed up by a phone call to the patient six weeks into their recovery to determine patient satisfaction and functional outcome. Pre and post operative haemoglobin levels and blood loss were also monitored, as well as whether the patient received spinal or general anaesthesia. All the above factors and how they pertained to the patients' recovery and satisfaction post-operatively were examined, interpreted and included in this audit.

## Feedback

*"Staff were brilliant"*

*"100% satisfied with care"*

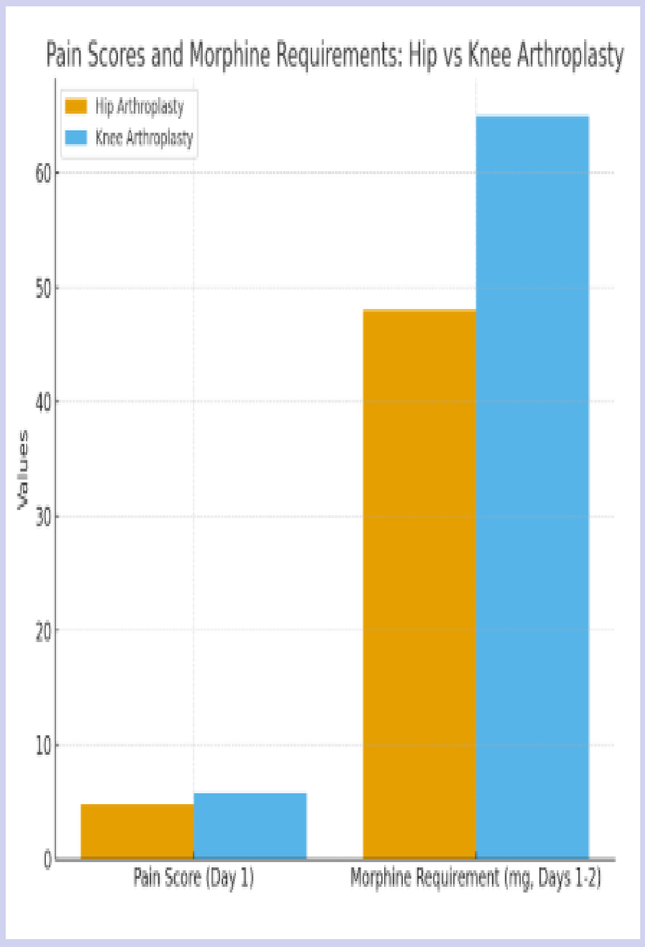
*"Very Happy with care "*

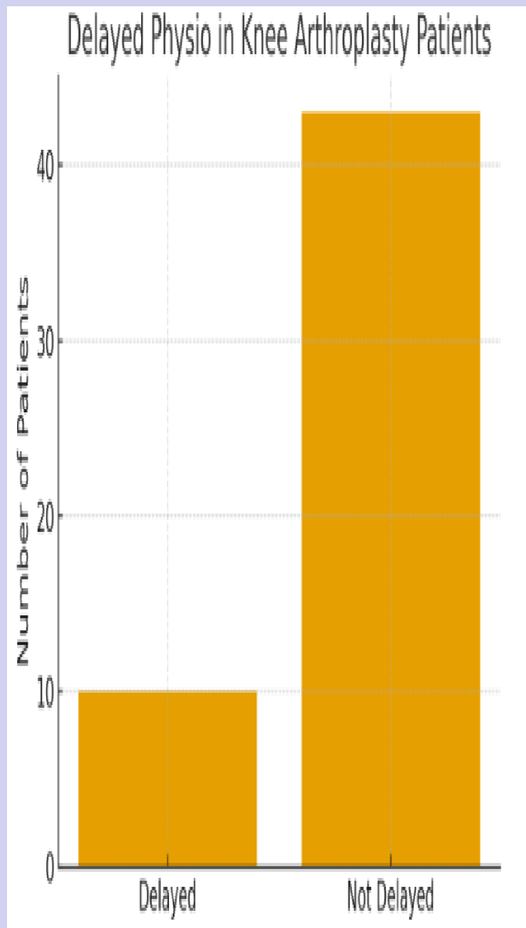
We were pleased with the satisfaction score we received for the overall care and the fact that 91% of the patients were mobilising independently at 6 weeks. There was a reduction in the percentage of patients requiring prescription analgesics post operatively; 21% compared to 36% pre-operatively. Hopefully these patients would continue to wean their opioid use.

## Demographics

| | Hip arthroplasty | Knee arthroplasty |
|---|---|---|
| Total no. of patients in audit | 94 | 53 |
| Average age | 69 yrs | 69 yrs |
| Male: Female ratio | 44:50 | 26:27 |
| Independent at home | 91 (96.8%) | 51 (96%) |
| Pre-op Hb (g/dL) | 13.5 | 13.6 |
| On prescribed analgesics Pre-op | 35 (37.2%) | 18 (33.9%) |
| Post op Hb (g/dL) | 10.7 | 11.4 |
| Day of mobilisation | 87/94 on Day 1 | 50/53 on Day 1 |
| Pain score Day 1 | 4.8 | 5.8 |
| Length of hospital stay | 4.3 (2-13 days) | 4.7 (3-13 days) |
| Mobilising independently at 6 weeks | 90% | 94% |
| Requiring prescribed analgesics at 6 weeks | 18% | 26% |
| Satisfaction at 6 weeks | 8.8 | 8.7 |

## Key Findings and Results




## Conclusion

The pain scores on Day 1 and Day 2 were 4.8 and 5.8 respectively (out of 0 -10 pain scale) for the hip and knee arthroplasty patients. Total knee replacements would be considered the more painful procedure and this is reflected in the higher opioid consumption over the first 48 hours post-operatively.

## Recommendations

The overall recommendation from the PROSPECT Working Group for pain control following primary total knee arthroplasty defines our Fast Track regime (see above). In addition the Group recommend a single shot adductor canal block pre-operatively or if this cannot be done, then intracthecal morphine 100 mcg is recommended.[5]

## References

1.Kehlet H. ***Fast-track hip and knee arthroplasty***. Lancet2013; 381:1600-2
2.Petersen PB, Koehler H, Jorgensen CC, Lundbeck Foundation centre for Fast-track H, Knee Replacement Collaborative G**. *Improvement in fast-track total hip and knee arthroplasty: a prospective multicentre study of 36,395 procedures from 2010 to 2017***. Sci Rep 2020; 10(1):21233
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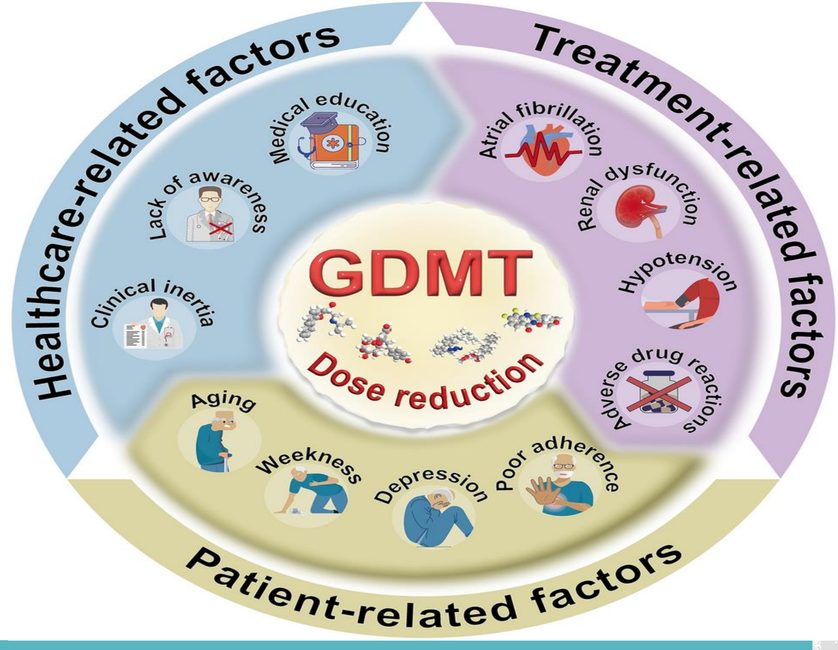
4.Husted H. ***Fast-track hip and knee arthroplasty: clinical and organisational aspects***. Acta Orthop supplement. 2012 Oct;83(346):1-39.
5. Lavand'homme PM, Kehlet H, Rawal N, Joshi GP**. *Pain management after total knee arthroplasty, PROcedure SPEcific Postoperative Pain ManagemenT recommendations,*** European Journal of Anaesthesiology 39(9): p743-757,Sept 2022

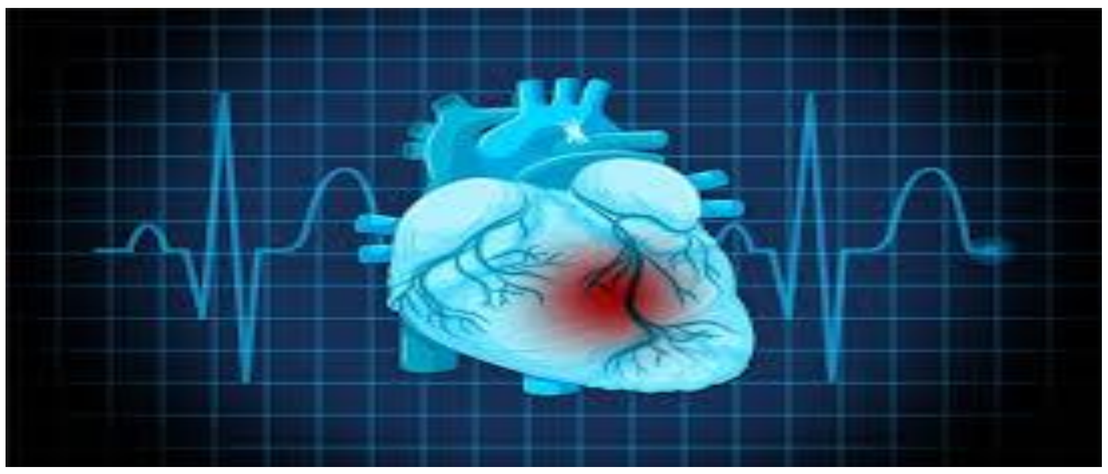
# Guideline-Directed Medical Therapy (GDMT) in Patients with Heart Failure in the Rehabilitation ward at St Ita's Community Hospital: Quality Improvement Project

Aanab HagAhmed[1,2], Tala Abdullatif[1,2], Aditi Rajpatty[1,2],Swraj Singla[1,2], Asad Raza[1,2], Esraa Siddig Hashim Ismail[1], Jet Maharaj[1,2], Jai Deep[1,2] , Ahmed Gabr[1,2], Margaret O' Connor[1,2]

[1]University Hospital Limerick, Limerick, Ireland. [2]St. Ita's Community Hospital, Limerick, Ireland



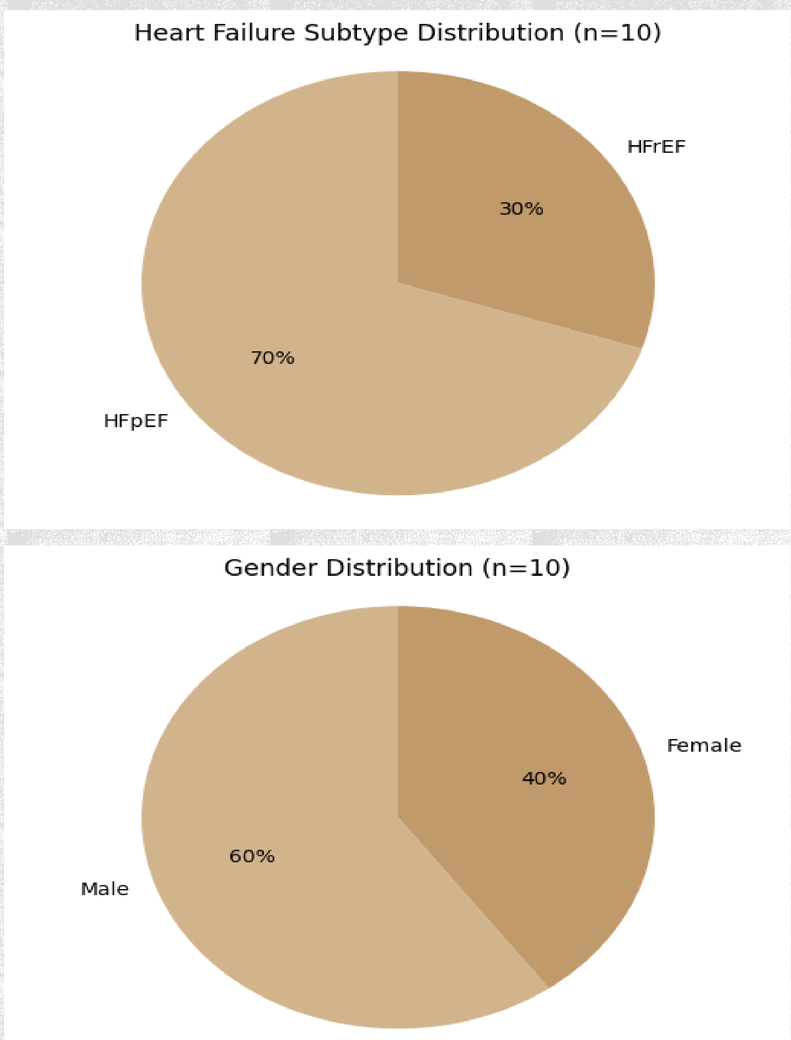

**Background:** In 2021, there were 56.5 prevalent cases of heart failure globally. There were 27.3 million prevalent cases in females and 29.2 million cases among males[1]. Guideline-Directed Medical Therapy (GDMT) is essential for improving morbidity and mortality in patients with heart failure (HF) [2,3]. An initial audit in the rehabilitation wards of St Ita's Hospital identified suboptimal adherence to the 2023 Focused Update of the 2021 European Society of Cardiology guidelines for acute and chronic HF management. A targeted educational intervention for medical doctors was subsequently implemented.



**Aim:** This re-audit evaluated the impact of implementing structured and targeted educational interventions on healthcare professionals' compliance with established guideline-directed medical therapy (GDMT) prescribing practices in the management of patients with heart failure.

**Methods:** Patients admitted to the rehabilitation ward with a documented diagnosis of HF between October 2025 and January 2026 were included. Prescribing practices were assessed against the 2023 ESC guideline update and compared with the initial audit cycle. Teaching sessions focused on HF phenotypes, GDMT principles, and optimisation of evidence-based pharmacological therapy. Patients were stratified by HF subtype. Those with heart failure with preserved ejection fraction (HFpEF) were assessed for diuretic use, sodium–glucose co-transporter-2 inhibitors, and comorbidity management, while patients with heart failure with reduced ejection fraction (HFrEF) were assessed for compliance and adherence.

**Results:** Ten patients were included in the re-audit, compared with 22 patients previously. Six patients were male (60%) and four female (40%). HFpEF accounted for 70% of cases and HFrEF for 30%. This re-audit demonstrated improved adherence to guidelines, including increased use of SGLT2 inhibitors in HFpEF and appropriate diuretic prescribing in both HFpEF and HFrEF where no contraindications existed. Overall adherence to guideline-based therapy improved following education, although residual gaps in optimisation persisted.




**Conclusion:** Targeted education significantly improved adherence to guideline-recommended heart failure (HF) therapy. Ongoing audit and continuous medical education are crucial to sustaining these improvements and optimizing patient outcomes in the rehabilitation setting over time.

**References:**

1. Roth GA, Dorsey H, Decleene N, Razo C, Stark B, Johnson C, et al.; The Global Burden of Disease Study Collaborators. The global burden of heart failure: a systematic analysis for the Global Burden of Disease Study 2021. *Eur Heart J.* 2023;44(Suppl_2):ehad655.876. doi:10.1093/eurheartj/ehad655.876
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# “Right Product, Right Reason, Stop Unnecessary Pad Usage”

## A Multi-disciplinary Approach to Continence Promotion

Authors: Aoife O’Brien (CNM3 Quality and Innovation), Louise McLoughlin (CNM 3 Medical Directorate) and Philip Williams (Senior PT FITT) on behalf of:
The Continence Promotion Working Group

# Introduction

The Continence Promotion Working Group recently conducted a survey (May 2025) which revealed significant variation in staff knowledge and practices around urinary incontinence across Nursing (including student nurses), PT, OT and HCAs (n=200).

Misconceptions, such as assuming incontinence is a normal part of aging and assuming a patient is incontinent if placed in incontinence wear was evident (30%). Although staff self-reported confidence in product selection, actual knowledge was limited with poor recognition of inserts among staff. Ordering patterns reflected this, with wrap-arounds (370,455 approx) and pull-ups (56,627 approx) dominating use, while inserts were least frequently ordered.

The working group highlighted the current “insert” to be unsuitable due to excessive bulk, recommending instead TENA Comfort Mini Extra (11cent per item, 250ml absorbency) and TENA Comfort Mini Super (15.7cent per item, 400ml absorbency) as preferred products on the basis of both cost-effectiveness and quality.

Beyond product-related issues, staff also identified systemic barriers, including limited access to patients’ own underwear. Almost half (48%) of respondents reported resorting to incontinence wear due to the lack of underwear thus potentially increasing the risk of hospital-acquired incontinence.

FITT assessments play a pivotal role in determining baseline functional status (including continence status) for older patients prior to ward transfer. However, discrepancies often arise between continence status at initial assessment and continence care provided on the ward. Such inconsistencies can lead to inappropriate use of containment products and poor documentation thus impacting patient dignity and increasing the risk of hospital acquired incontinence.
The reason for the audit was to determine if staff perception reflected actual practice.

# Aims

To assess the continuity and appropriateness of continence care for patients identified as continent by the FITT team upon transfer to inpatient wards.
The objective was to devise an audit tool that captured information re: continence care at ward level (Figure 2.).
The SMART model (Figure 1.) was utilized to ensure the data collection was completed successfully within a 6.5-week timeframe. The audit tool took both a Quantitative and Qualitative approach using open and close ended questions.

# Methods

Figure 1.

| | |
|---|---|
| **Specific:** | **Patients identified as continent by FITT were determined and their continence care evaluated at ward level.** |
| **Measurable:** | The percentage of the following was measured:<br>• Accurate and complete continence documentation –comparing FITT and nursing documented assessments.<br>• Inappropriate use of continence products applied.<br>• Unnecessary urinary catheterisation insertion.<br>Approach: Patient or NOK/family member had to agree to take part in the audit.<br>Patient/family feedback was obtained on interview. Patients who did not agree to take part were excluded from the audit. |
| **Achievable:** | Data was collected over a 6.5 week period – hospital wide.<br>Audit commenced on the 7/7/25 and last data collected on the 21/8/25 |
| **Relevant:** | Points of good versus the need for improved practice in communication, documentation, or care planning that may affect continence care was measured. |
| **Time-bound:** | Data collection, analysis, and dissemination of results within 10 weeks from the audit start date was achieved. |

Figure 2.

Data Collection Proforma

*Initial of patient:_____*

*Verbal Consent obtained by auditor from patient to carry out assessment Y/N (If no, do not proceed with the audit)*

***Audit Tool***

*Q.1 Is there evidence of baseline continence function documented on the SMART-CAT or FITT form Y/N*

*Comment _____*

*Q.2 Does this information match the ED nursing assessment documentation? Y/N*

*Comment _____*

*Q.3 Does this information match the nursing admission booklet documentation at ward level? Y/N*

*Comment _____*

*Q.4 Does the patient or NOK (as appropriate) agree with the assessment made? Y/N*

*Comment_____*

*Q.5 Is the patient currently in inappropriate incontinence wear? Y/N*

*Comment _____*

*Q.6 Has the patient developed hospital acquired incontinence? Y/N (If yes, please comment on how long the patient has been admitted for)*

*Comment _____*

*Q.7 If required, is there a clear and individualised continence care plan in place? Y/N/N/A*

*Q.8 Were the correct continence products available to the patient? Y/N/N/A*

*Comment _____*

*Q.9 Does the patient have any further comments regarding their continence/toileting needs?*

*Comment _____*

*Q.10 Does the patient have a new urinary catheter inserted? Y/N/N/A*

*Q.11 If the patient has a urinary catheter inserted, is there a clear clinical reason? Y/N/N/A*

The initial target was to obtain >30 audits across the hospital.
Head of department(s) – Nursing, PT, and OT were informed via email about the audit being conducted.

The audit team approved the audit tool Proforma prior to distribution (Figure 2.).
Email between FITT and assessors took place daily (Mon-Friday) with the following request:
“As part of journey mapping continent patient’s experience– can you please provide the following detail on admitted patients (>75 years old) deemed continent during FITT assessment?
- Patients Name
- Name of ward

Please exclude the following patients: those with long term indwelling catheters pre-admission / have longstanding incontinence”

The assessors listed the patients name and followed their inpatient journey.
Sample Size: In total, data was collected from 85 patients, which was greater than the initial target- the reason for same was to obtain approximately 10% of the hospital's population.

Average Age of patients included in the audit -78 years old
Number of male patients n=41
Number of female patients n=44
Patients were categorized into two colors Green and Yellow.

# Results

Green patients (n= 46) 53% nil risk identified with regards to continence wear and were in the right product – underwear. These patients did not require follow up. However, care plan/ continence screening discrepancies were noted.

Yellow patients (n=39) 46% risk identified as needing follow up for the following reasons:
- If a catheter was inserted on admission
- The patient was placed into incontinence wear when deemed continent
- The patient developed hospital acquired incontinence
- There was assessment screens/care plan discrepancies

Yellow categorized patients were followed up within 7 days – follow up varied from day 1 – day 7 post initial review.

Over half of screens (56%) differed from baseline and 25% were incomplete. In particular 15% of patients who were deemed baseline continent described baseline incontinence issues during interview which was not picked up upon initial screening.
More than half (52%) had no clear plan documented, with 20% using the abbreviation PUIT.
11% of care plans stated the patient was continent however at time of audit patient was in incontinence wear.

Of those at risk (yellow group, 46%), 22% of baseline continent patients were placed in incontinence wear during admission, and 8% wore incontinence products at home for the following reason “just in case”. Inappropriate use of continence products was accelerated by lack of access to underwear (11%) and underuse of available underwear (12%).
13% patients developed hospital acquired incontinence. 13% had a new urinary catheter inserted, with evidence of routine incontinence wear application despite baseline continence.
Appropriate inserts remained under-utilized due to a lack availability, despite 20% patients who would have benefitted from their use.

The audit highlights gaps in product knowledge and access to appropriate products. There was evidence of inconsistent screening and documentation practices. The audit emphasizes systemic reliance on incontinence wear hospital wide which reflects the initial survey finding of staff attitudes and knowledge.

# Recommendations

The continence promotion working group’s strategy “Right Product, Right Reason, Stop Unnecessary Pad Usage” is well underway.

**Phased approach for the following actions:**
**Phase 1:**
An application for TENA inserts was applied for and approved by procurement.
By the end of October 2025, all wards in all directorates have a continence board depicting the following:
Product selection criteria – A traffic light system (Figure 3.) to guide staff in choosing the right (in)continence wear based on the need of their patient. Product codes are displayed on the board to ensure product accessibility. With the idea the person applying the incontinence wear is accountable in choosing the correct product based on the patients need.
To improve understanding of patient’s continence needs, it is advised for all MDT (inclusive of HCA, Nursing, OT and PT) to educate oneself on the types of urinary incontinence (Figure 4.) and embed a culture of asking patients and documenting the following in both assessment and care plan:
**What type of underwear do you wear at home?**
**Do you ever leak urine when you cough, sneeze, or laugh?**
**Do you ever experience any loss of bowel control?**
**Do you have trouble getting to the toilet in time?**


Figure 3.

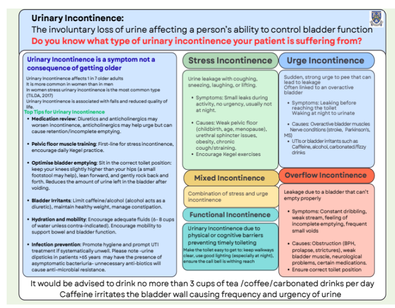



Figure 4.


Figure 5.

TARGET toileting (Figure 5.) was re-launched at the latter end of 2025 – A structured approach involving multidisciplinary collaboration to enable toileting opportunities, reduce incontinence, and support functional independence/baseline by preventing unnecessary pad use or urinary catheterisation.
**Phase 2:**
- To improve communication regrading continence status, the continence promotion working group plans to evaluate documentation related to both screening and care planning. This has yet to be discussed within the group.
- To introduce a KANBAN system across all clinical areas to support efficient stock replenishment and improve product accessibility.
- Empowering patients and their families to ensure maintain an adequate supply of underwear will be a key focus 2026.

A dedicated project lead (A.B/A.O.B) will oversee the roll out, training schedule and auditing throughout 2026.

# Acknowledgements

Special thank you to all members of the Continence Promotion Working Group and indeed staff of all disciplines for their continued efforts in promoting continence hospital wide.
Thank you to Sinead Connolly (DON), Annette Butler (Deputy DON – Project Lead Continence Promotion Working Group) and the wider Nursing Executive team, Louise McLoughlin (CNM3 Medical Directorate), Hannah Graham (ANP Urology), Maria Greene (CNM3 TUN), Jennifer Brady (CNM2 Urodynamics), Lissy Martin (CNM2), Sindhu Gada (CNM2), Neasa Hoey (CNM2), Rachel Swords (CNM2), Christina Kelly (HCA), Luke Tyrrell (HCA), Grainne Maher (Clinical Specialist OT), Sophie Reilly (OT), Paul Bernard (Occupational Therapy Manager in charge III), Ivan Clancy (Physiotherapy Manager) and Dr. Michelle O’Brien (Consultant Physician in Geriatric Medicine) for their guidance and continued support in driving this initiative.

***For further information please email:*** *aoifeobrien@Beaumont.ie*

*Bibliography available upon request*

FSS Bhaile Átha Cliath
agus Lár na Tíre
HSE Dublin and Midlands

# From Paper to Real-Time: Digitising Deteriorating Patient Audits to Strengthen Quality Improvement

**Karen Davis Holden[1], Cora Flynn[1]**

[1]HSE Dublin and Midlands

## BACKGROUND

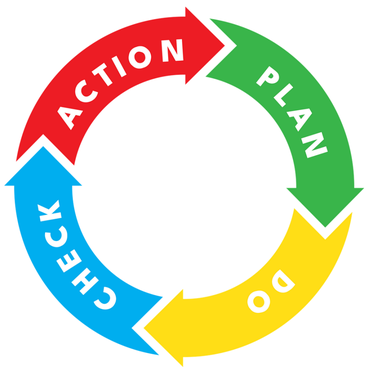
Medical E-Governance (MEG) is a digital audit tool which was utilised to facilitate the collection of Early Warning Scores (EWS) and sepsis audits.

The platform supports HSE Dublin and Midland acute sites in adhering to the national clinical guidelines on the frequency of audits and documenting quality improvement initiatives.

## AIM

To implement and extend the digital platform (MEG) for Deteriorating Patient Improvement Programme (DPIP) audits and quality improvement (QI) actions;

- Real-time access to results
- Evidence of compliance with national clinical guidelines across sites




## METHODS

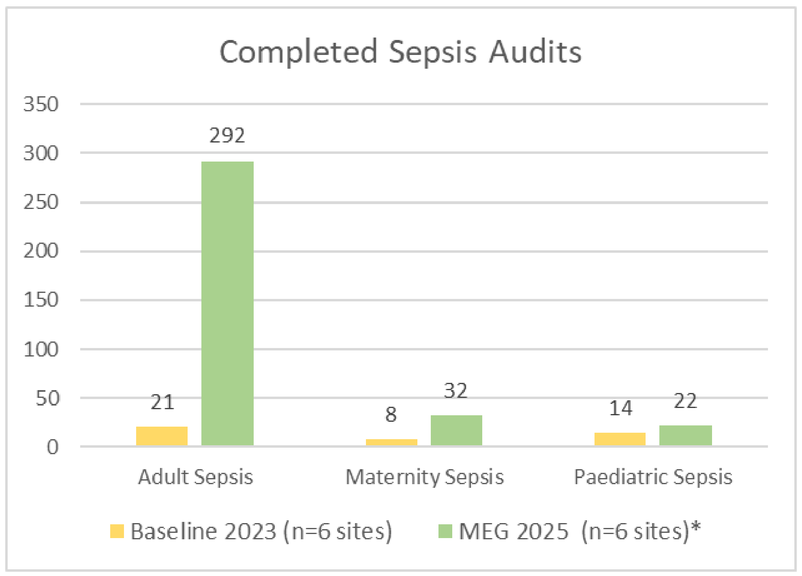
A QI approach using process mapping and PDSA:

- Workshops to standardise the audit processes
- Baseline data was collected (2023) and compared (2025)
- User evaluation survey 8 months post-implementation

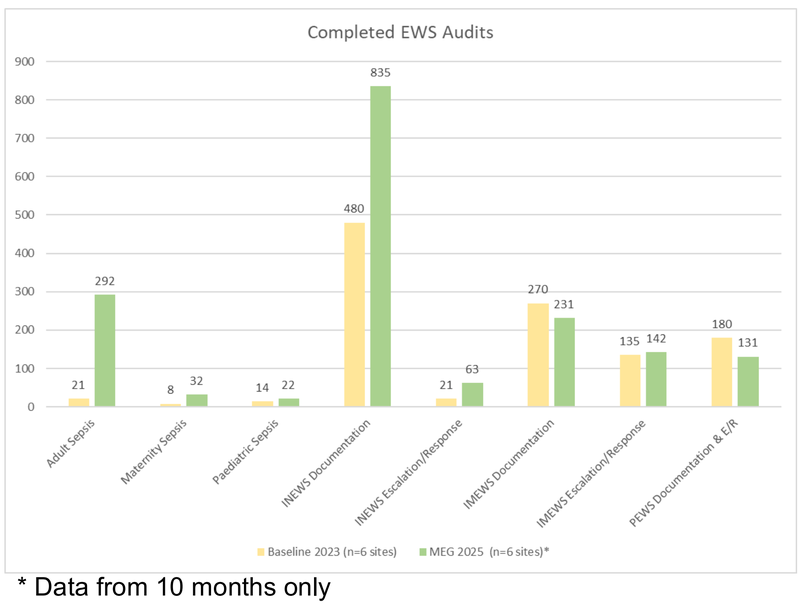
Audits comprised of:

- National Sepsis Management Guidelines
- Irish National Early Warning System (INEWS v2)
- Irish Maternity EWS (IMEWS)
- Irish Paediatric EWS (PEWS)

## RESULTS




* Data from 10 months only




* Data from 10 months only

Gives greater oversight to the audits, results are available to all services and the MDT team

The QIP section isn't as well developed as I'd like

## POST-IMPLEMENTATION SURVEY

**100%** — **Standardisation**
Agree the implementation of the MEG audit platform supported standardisation of the EWS/Sepsis audit processes

**85.7%** — **Accuracy**
Agree audit results and reports are accurate and easy to generate

**85.7%** — **Timesaving**
Agree completing audits on the platform saves time compared to paper/manual methods

**100%** — **Risk Identification**
MEG effectively / adequately supports the identification, escalation, and monitoring of clinical risks identified through audit

**100%** — **Positive Impact**
MEG had a positive/ very positive impact on auditors and clinical staff involved in audits

**(n=7)**

## FINDINGS

Digitisation of the DPIP audit process:

- Improved efficiency
- Reduced duplication
- Enabled real-time visibility of audit findings and Quality Improvement actions
- Standardised audit tools and improved dashboards and committee reports
- Supported consistent data collection and improved monitoring of compliance with all EWS and sepsis national clinical guidelines

## FUTURE DIRECTION

- Refine reporting
- Expand user engagement
- Continued evaluation of the impact on audit completion rates and patient safety outcomes

## ACKNOWLEDGEMENTS

- CTTO, Site DON's, Practice Development ADONs & CSFs
- HSE Dublin and Midlands workshop participants

# Bridging the Gap: Development of an Evidence-based Group Pelvic Floor Education and Exercise Programme for Pelvic Health Physiotherapy Services

R. McGuinness, S. Moore

Our Lady of Lourdes Hospital, Drogheda

## INTRODUCTION:

Pelvic floor dysfunction is highly prevalent across the lifespan of a woman and is associated with significant physical, psychological and social impact. Both the 2021 NICE Guidelines and the 7th ICI Guidelines (2023) recommend a programme of supervised pelvic floor muscle training (PFMT) of at least 3-months should be offered as first-line conservative therapy for women of all ages with stress or mixed urinary incontinence (SUI/MUI). Group PFMT has been proven to be less costly than 1-to-1, while offering equivalent clinical effectiveness and patient acceptability. (Chantale Dumoulin et al, 2020).

With this in mind, we developed a 12-week Pelvic Floor Education & Exercise Programme and offered all patients with SUI/MUI the opportunity to attend this weekly class, in an attempt to improve adherence and compliance with PFMT, in-line with best practice.

## OBJECTIVES:

- Develop a pelvic floor education and exercise programme for patients with urinary incontinence (SUI/MUI).
- Confirm the effectiveness of supervised group PFMT in SUI/MUI/POP patient group using qualitative and quantitative measures.

## METHODOLOGY

- Process mapping helped identify key steps and stakeholders required to design the programme which was led by a pelvic health physiotherapist, consisting of exercise and education for 1 hour, once a week, for 12 weeks.
- Inclusion/ Exclusion criteria was established based on literature review.
- Referrals were accepted from physiotherapists on the pelvic health team & from primary care pelvic health physiotherapists, for patients who met the inclusion criteria, integrating hospital and primary care physiotherapy services.
- Using PDSA cycles, we tested small-scale changes, gathered patient feedback and incorporated findings into subsequent groups.

## RESULTS

- 46 patients have completed the programme, with 2 drop outs due to childcare / work constraints.
- >75% attendance rate was recorded across the 12-week programmes (>9 out of 12 classes attended).
- 77.3% improved on their ICIQ-SF after the 12 week programme, and of those that improved, 100% had maintained ICIQ scores at 20 weeks with a further improvement in 76% of patients.
- 84% of patients improved on their PGI-I with the median number of 2, correlating to 'much better'.
- No patients' symptoms worsened.
- Pelvic Floor strength improved for 97.56% of patients assessed on vaginal examination graded using the PERFECT scale.
- Time saved providing a pelvic floor education & exercise class is equivalent to 13.97 weeks WTE physiotherapist.

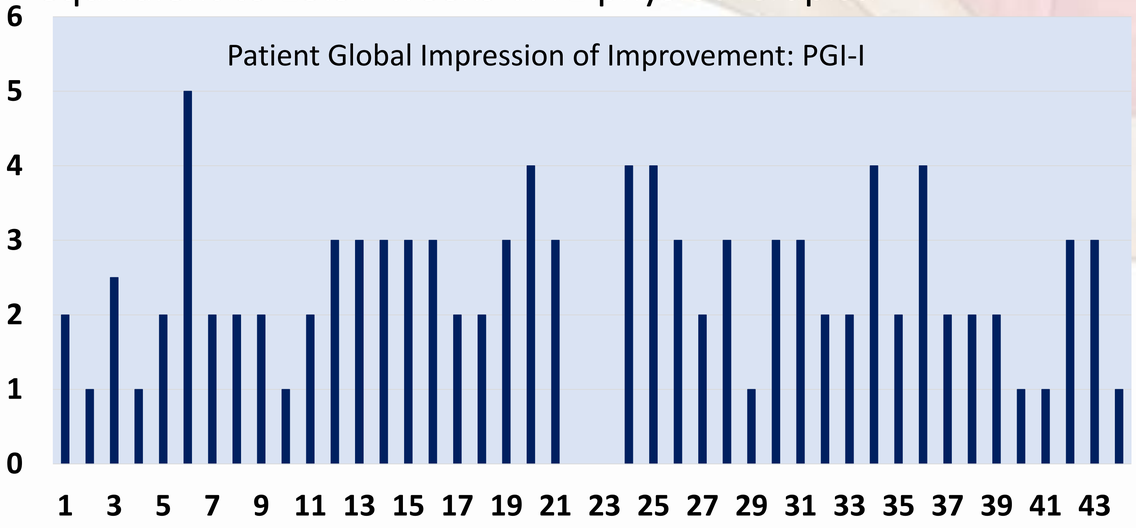



*Figure 1. Patient Global Impression of Improvement*

"The mix of people and ages at different lifestages was excellent- learned a lot from other peoples experiences. Weekly talks interesting"

"To have regular input re the correct way to do exercises was great. Enjoyed being in a group".

"Education piece was very beneficial; all our embarrassing questions were answered. Highly recommend".

"Classes were fantastic but would be great to have evening classes or online course"

*Figure 2. Patient Feedback*

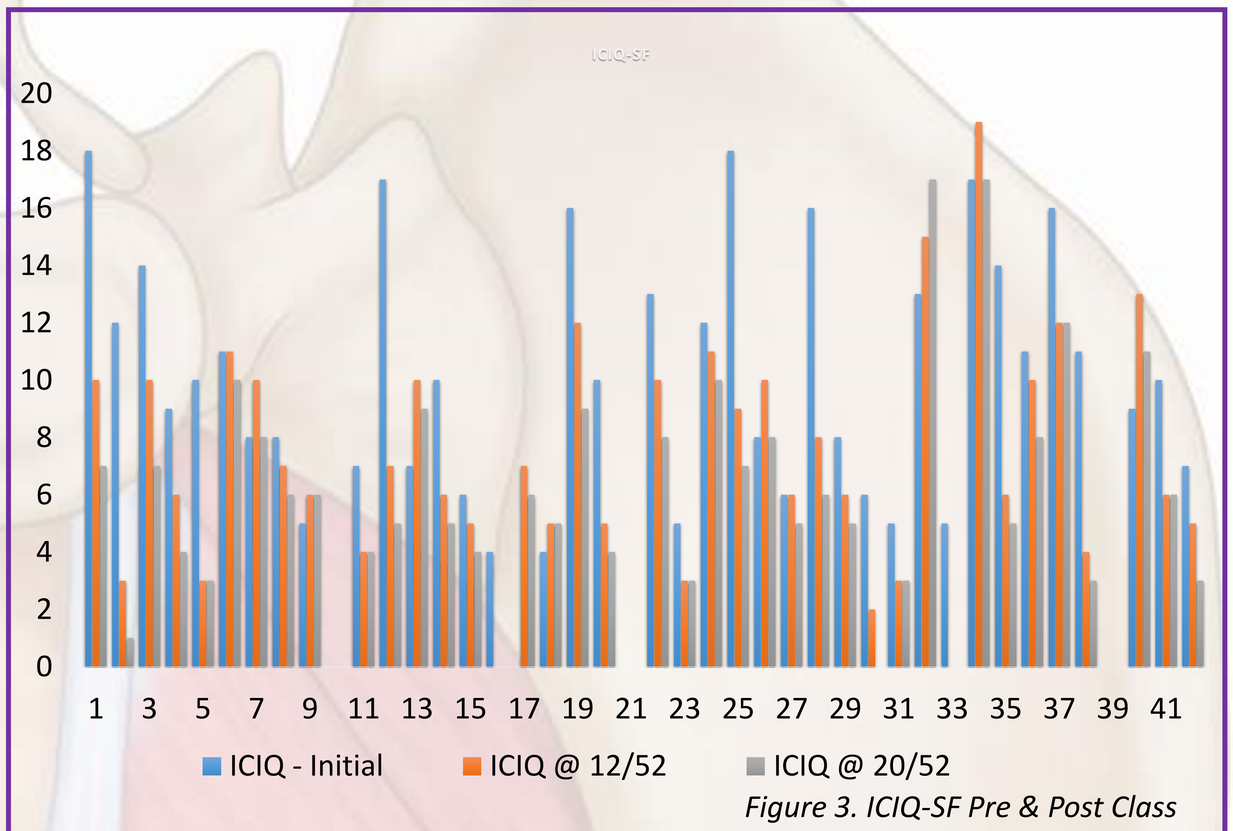



*Figure 3. ICIQ-SF Pre & Post Class*

1hr class x 12 =12 hrs

6 patients/class = equivalent to 72hrs of 1:1physiotherapy input (12 x 6=72hrs)

8 programs completed to date = equivalent of 1:1 physiotherapy input (72hrs x 8 programs)

576 hours of input delivered in 96 hours (12 classes x 8 programs = 96)

Classes have freed up 480 hours of Clinical Specialist Physio time (576-96= 480 hours) vs 1:1

Time saved is the equivalent of 13.71 weeks WTE

*Figure 4. Time saved running group PFMT classes*

## Conclusion:

Group Pelvic Floor Education and Exercise Programme is an effective treatment option for patients with urinary incontinence and demonstrated high acceptability and positive outcomes from patients, maintaining best practice while reducing clinician workload allowing time to dedicate to more complex patients.

### Future Plans

Integrate this class within the post-natal hub and Primary Care pelvic health physiotherapy services.

Develop a virtual model of the class, to cater for those unable to commit to face to face classes.

Develop a referral pathway for patients following prolapse repair to attend the Pelvic Floor Education & Exercise Programme to enhance outcomes post-operatively

# Enhancing Compliance with Surgical Antibiotic Prophylaxis: A Quality Improvement Approach to Prevent Surgical Site Infections

**Triona Murphy CNS SSIS**

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta

An Academic Partner of Trinity College Dublin

## Introduction:

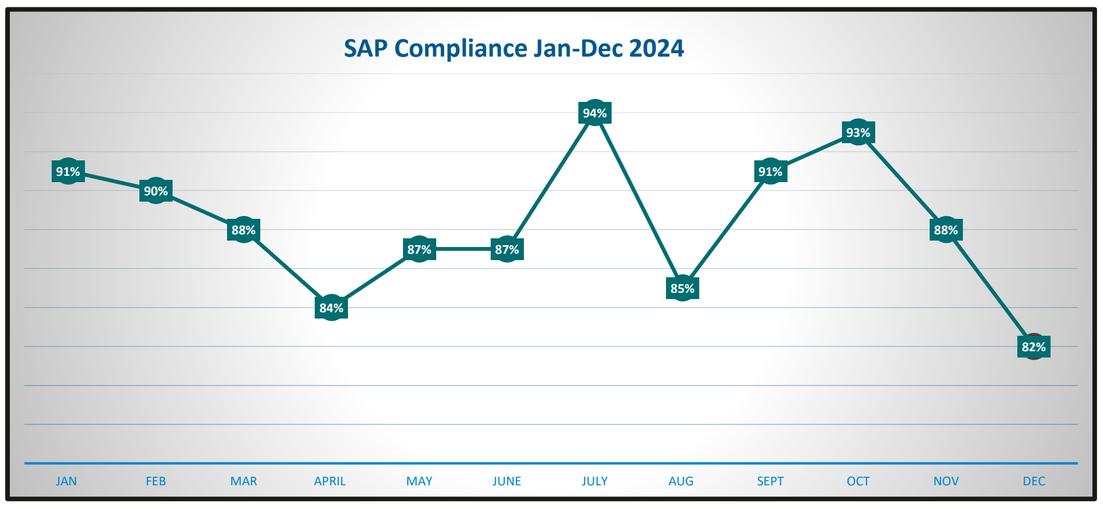
**Surgical site infections (SSIs) are among the most common healthcare-associated infections and are associated with increased morbidity, prolonged hospital stay, additional costs, and even mortality. Surgical antibiotic prophylaxis (SAP) is a critical strategy to prevent SSIs. Administering the appropriate antibiotic, at the right dose, and at the correct time—typically within 60 minutes before incision—reduces bacterial load at the surgical site and significantly lowers the risk of postoperative infection.**

**Ensuring compliance with SAP guidelines is essential, as incorrect timing, dosing, or choice of antibiotic diminishes its protective effect and may contribute to antimicrobial resistance. Improving adherence to prophylaxis protocols is therefore a key component of patient safety and quality surgical care.**

**AIM: Surveillance of surgical site infections (SSI) at Tallaght University Hospital (TUH) revealed variable compliance with surgical antibiotic prophylaxis (SAP) guidelines. The review of a cluster of SSI in 2024 noted that non-compliance in SAP was a risk factor in 60% of cases. Overall non-compliance in confirmed SSI in 2024 was rated at 14%. Preliminary efforts to improve compliance by adding posters and signage showed limited impact Our aim was to improve compliance with compliance rates with SAP as per TUH guidelines.**

The criteria for the audit is:
That SAP was administered within 60 mins off knife to skin time.

- The appropriate SAP was administered according to TUH guidelines.
- SAP appropriate for antibiotic allergy.
- Length of surgery and additional doses of SAP administered
- Blood loss and additional doses of SAP administered




## Methods:

**This quality improvement project was conducted using the Plan–Do–Study–Act (PDSA) methodology to improve compliance with surgical antimicrobial prophylaxis (SAP) guidelines in orthopaedic surgery.**

### 1. PLAN:

**Baseline concerns regarding variability in SAP prescribing and documentation were identified through existing SSI audit and following HSE external audit. Following Stakeholder engagement, additional Text was added to existing Pre-operative Patient safety "TIME OUT "Check lists to include specifics of SAP for Orthopaedic Surgery as per TUH Guidelines.**

Tallaght University Hospital


### 2. DO:

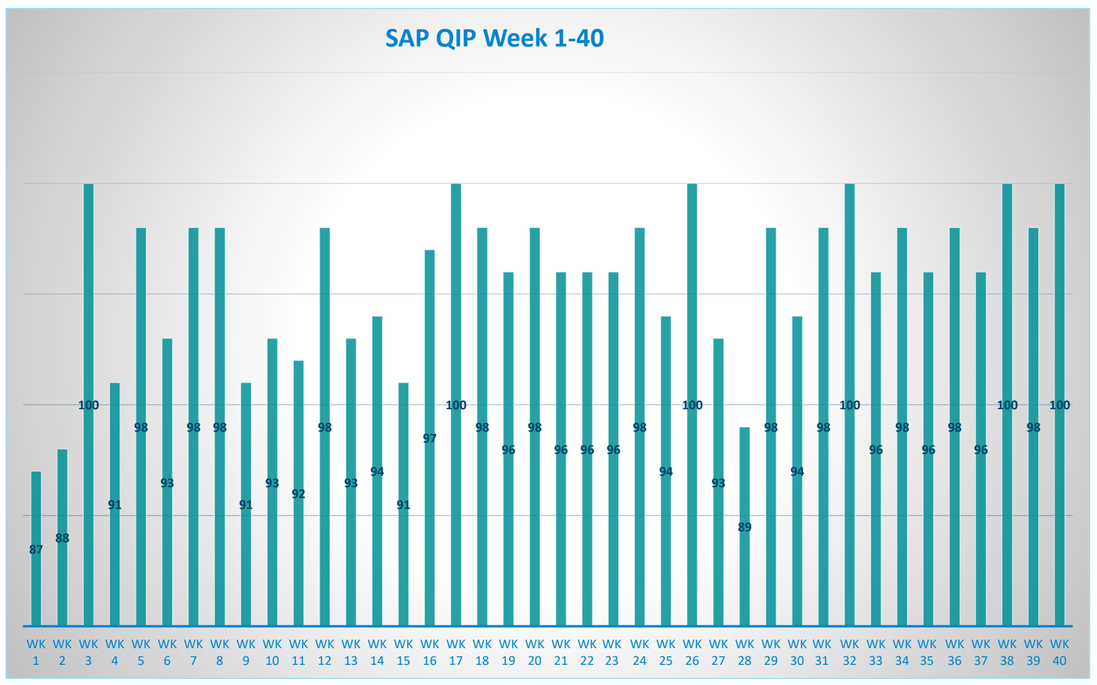
**A prospective audit was introduced encompassing all orthopaedic surgical procedures performed. Data was collected in real time to capture adherence to institutional SAP guidelines, including antibiotic selection, timing of administration, dosing, and duration. The weekly audit results were sent to the Orthopaedic and Anaesthetic Departments through the Peri-operative Directorate.**

### 3. STUDY:

**During the *Study* phase, additional data fields were incorporated into the audit tool to capture delays in SAP administration that occurred outside the direct control of the anaesthetist, such as delays related to radiological investigations.**

### 4. ACT:

**The primary outcome measure was SAP guideline compliance, with secondary measures including documentation completeness and reasons for delayed administration. Data were analysed descriptively and compared across successive PDSA cycles to assess change over time.**




**Following implementation of the PDSA cycle, consistent improvement in SAP guideline compliance was observed. As illustrated in the graph above, adherence rates increased across successive audit cycles, demonstrating that real-time data collection and iterative feedback effectively supported sustained compliance. These findings highlight the value of using structured quality improvement methodologies to identify barriers, refine processes, and achieve measurable improvements in clinical practice.**

# Collaborative dental care planning for patients with inherited bleeding disorders

## PROJECT DETAILS

Care planning with dental participation in the haemophilia and allied bleeding disorder multidisciplinary team meeting (MDT)

Ali M, Nolan B, Ahmed S, FitzGerald K, Kenny K

1 CHI at Crumlin, Dental Department
2 CHI at Crumlin, Haematology Department

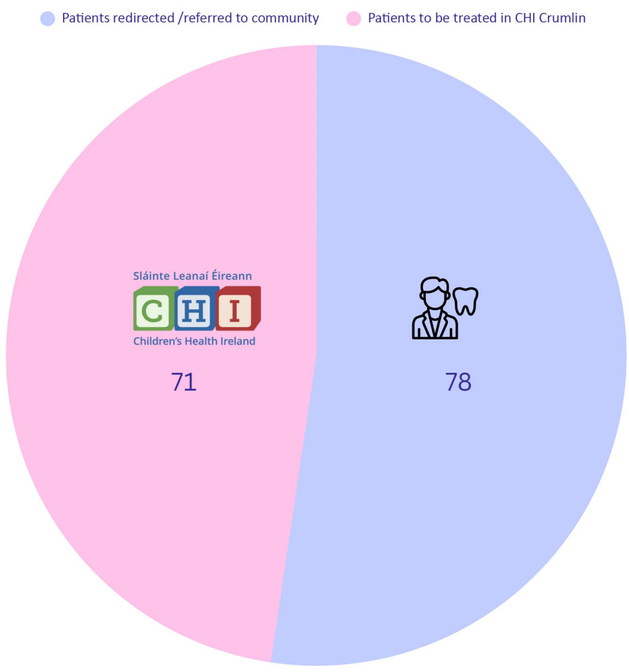
## AIMS & OBJECTIVES

1) To measure the number of dental patients discussed at the haemophilia and allied bleeding disorder MDT meeting over a 12-month period
2) To determine the proportion of patients suitable for the community setting
3) To highlight the value of a weekly MDT meeting for haemophilia and allied bleeding disorder patients requiring dental treatment

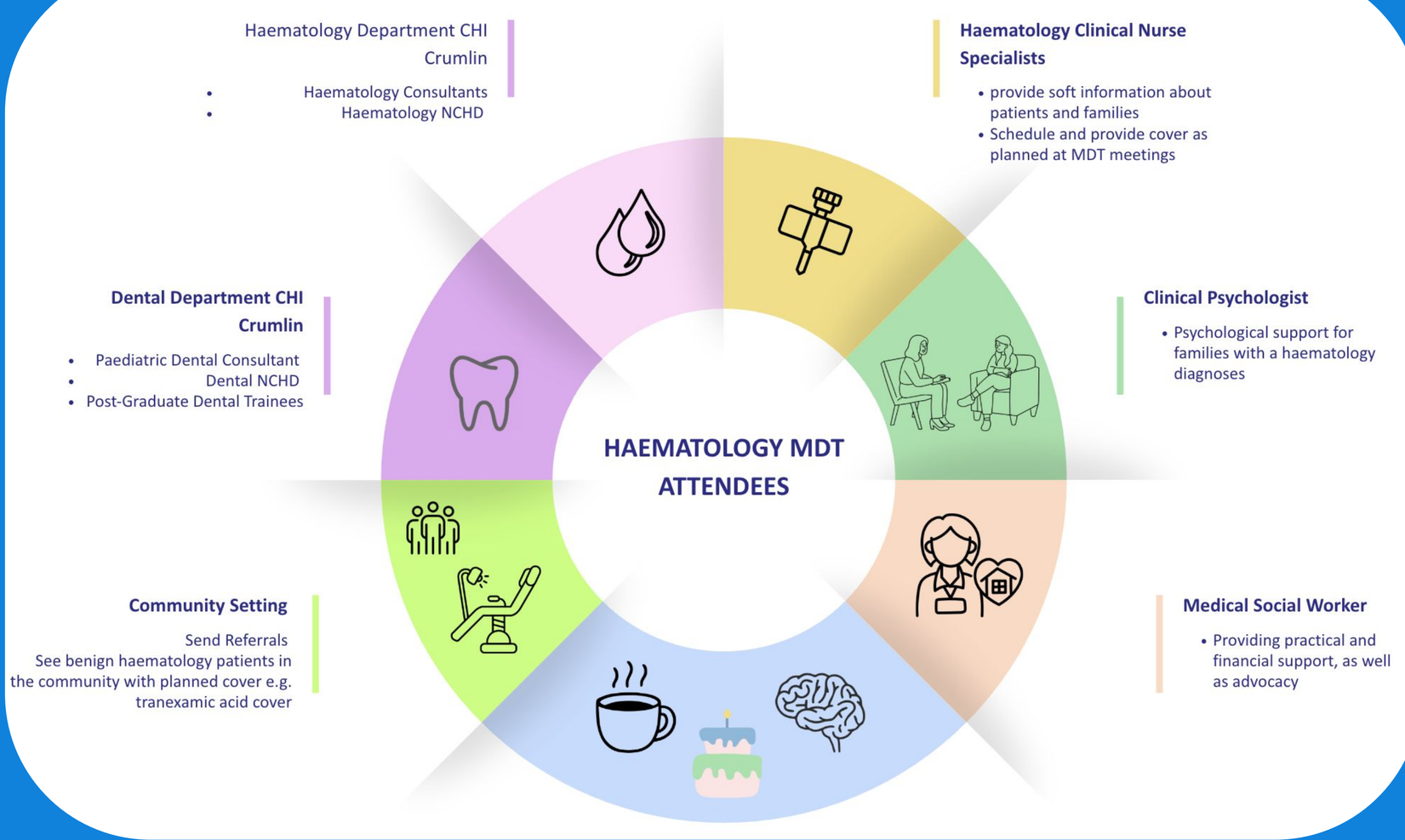
## BACKGROUND

- Children with inherited bleeding disorders including haemophilia and von Willebrand disease require co-ordinated, multidisciplinary care to optimise health outcomes
- Fragmented management can lead to complications
- This poster describes the structure, aims and outcomes of a weekly MDT meeting established to facilitate comprehensive care planning for this patient cohort.

## KEY RESULTS




- 149 patients were discussed
- 78 patients did not need care in a hospital setting and were referred to their local community dental services
- 71 patients required assessment and/or treatment in the hospital setting, and their haematological support was planned
- Outcomes from these meetings are logged in Indici - an electronic patient record and national database




## METHODS

- Retrospective analysis of dental/haematology MDT logbook for a 12-month period
- Results from each weekly MDT were logged into an excel spreadsheet
- Patients were categorised as :

1) suitable for treatment in the primary care /community setting +/- tranexamic acid
2) require dental treatment in the tertiary setting at CHI

## Benefits of the Haematology MDT

1) Improved efficiency : it is much easier to discuss a case and make a plan face to face as opposed to multiple emails / correspondence back and forth
2) Obtaining 'soft' information about families that facilitates accessing care e.g. levels of anxiety for the child, parental anxiety
3) Helps to overcome barriers to care, by redirecting patients who can be seen in the community setting closer to home - this is in line with Sláintecare
4) Coordination of teams, especially for complex care e.g general anaesthesia cases
5) Coordination of OPD appointments for the same day as Haematology appointments - this limits the need for multiple visits for families
6) Reduction in administrative time
7) Potential reduction in cost of care due to minimisation of patient appointments
8) No known reports of patients returning with bleeding complications after being referred to community dental services

Rialtas na hÉireann
Government of Ireland

Sláintecare.
Right Care. Right Place. Right Time.


# Audit of Compliance with Weight-Based Prescribing Guidelines for Paracetamol.

## St. Luke's General Hospital, Kilkenny, Ireland.

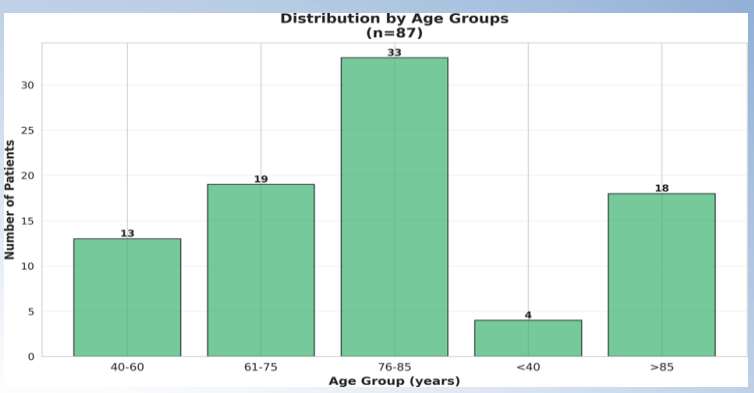
Dr. M.Z.Akram[1], Dr.R.Khan[1], Dr.M.B.Khan[1], Dr.I.Elsuni[1] Dr.H Khan[1], Dr. I R Sidhu[1], Dr. S.Rehman[1]

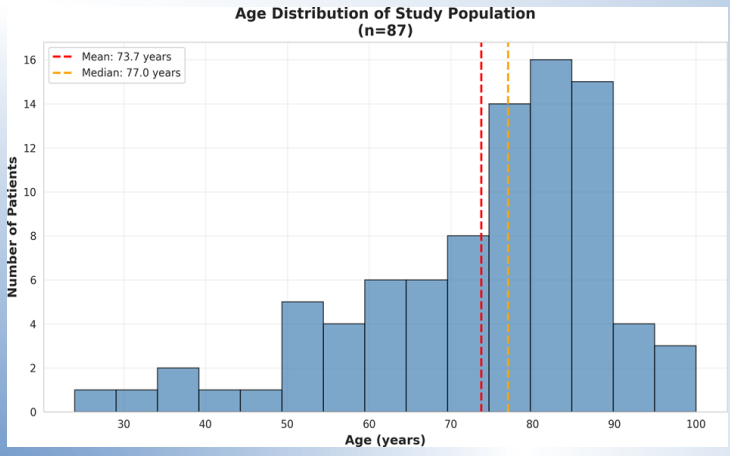
**Background:**
Paracetamol (acetaminophen) is one of the most commonly prescribed analgesic and antipyretic medications in hospital settings This clinical audit evaluated compliance with weight-based paracetamol prescribing guidelines at St. Luke's General Hospital, Kilkenny.

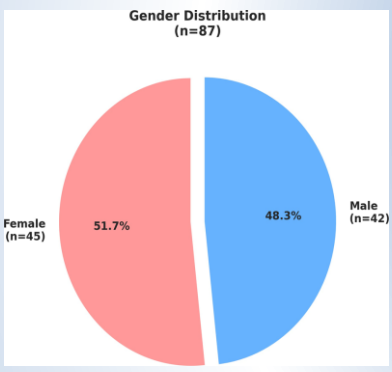
**Methods:**
This was a retrospective clinical audit of paracetamol prescribing practices conducted at St. Luke's General Hospital, Kilkenny, Ireland

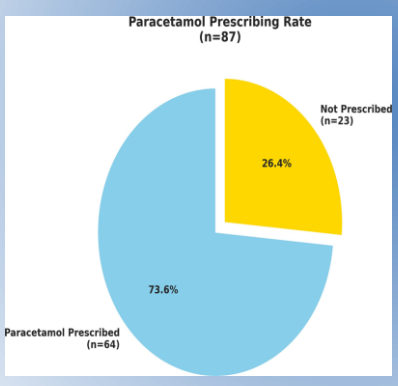
**Results:**
A total of 87 patients were audited, with 64 (73.6%) prescribed paracetamol. Among assessable cases, the compliance rate with weight-based dosing guidelines was 48.4% (31/64 patients). Weight documentation was recorded in 57.5% of cases.

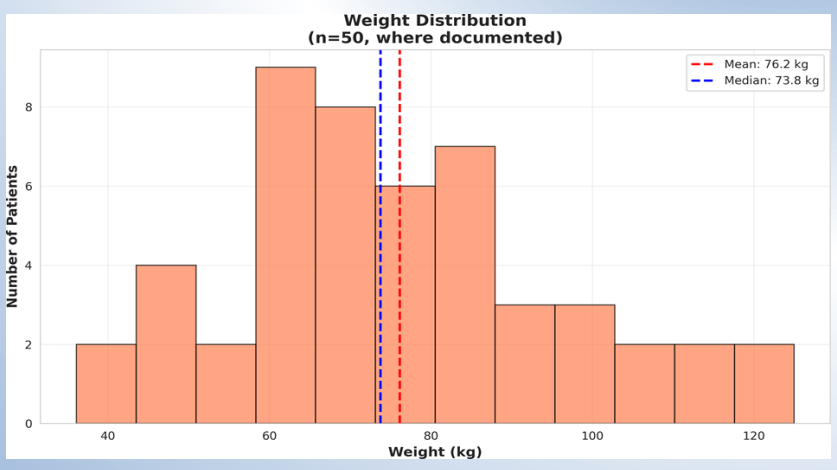
**Conclusion:**
These findings highlight significant opportunities for improvement in adherence to evidence-based prescribing practices and documentation standards.




**RECOMMENDATIONS**

**<u>Immediate Actions (0-3 months)</u>**

1. Mandatory Weight Documentation
Implement a policy requiring weight documentation for all admitted patients. Include weight as a mandatory field in admission documentation.
]Ensure weighing scales are available and accessible on all wards

2. Prescriber Education
Conduct educational sessions on weight-based paracetamol dosing guidelines. Distribute quick-reference guides and dosing calculators.
Include weight-based dosing in junior doctor induction programs

3.Audit Feedback
Disseminate audit results to all clinical staff. Present findings at departmental meetings and grand rounds.
Share individual prescriber feedback where appropriate

**<u>Short-Term Actions (3-6 months)</u>**

4.Electronic Prescribing Enhancement
5.Clinical Protocols
6.Pharmacy Intervention

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# Assessment of Echocardiography Request Appropriateness in the Medicine

Dr. Z. Akram[1] , Dr.R.Khan[1] ,Dr.M.B.Khan[1], Dr.I.Elsuni[1], Dr. N Basha [1] Dr. H Khan[1], Dr. I R Sidhu[1], Dr. S.Rehman[1]
Department of Cardiology and General Internal Medicine St Luke's Hospital, Kilkenny

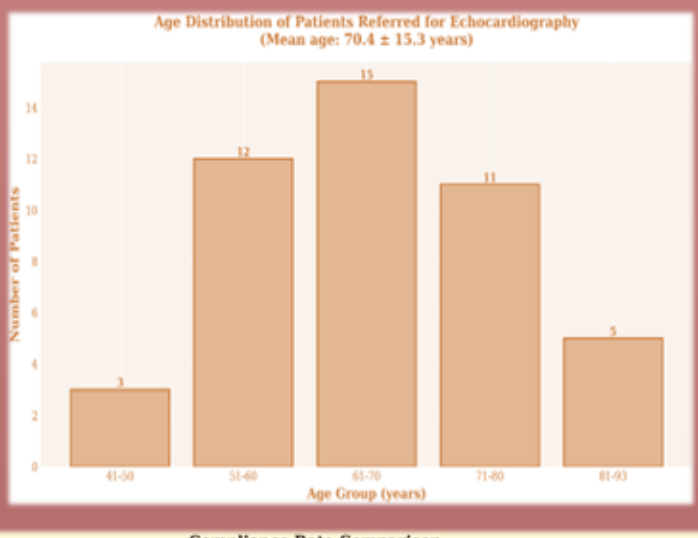
**ABSTRACT:**

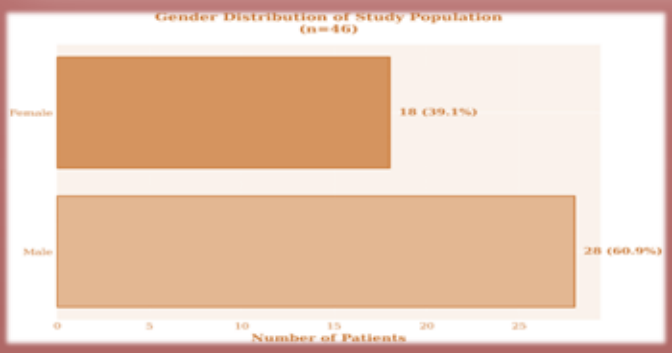
**Introduction**:This clinical audit evaluated the appropriateness of transthoracic echocardiography (TTE) requests originating from the Medicine Sub-Team at St. Luke's Hospital, Kilkenny, over a three-month period.

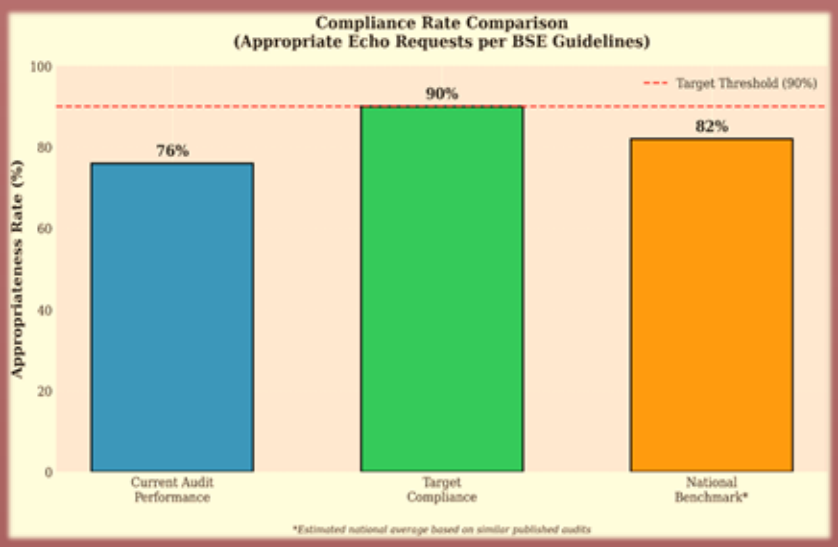
**Methods**:The audit was conducted to ensure alignment with the British Society of Echocardiography (BSE) clinical indication guidelines, which serve as the gold standard for evidence-based echocardiographic referrals.

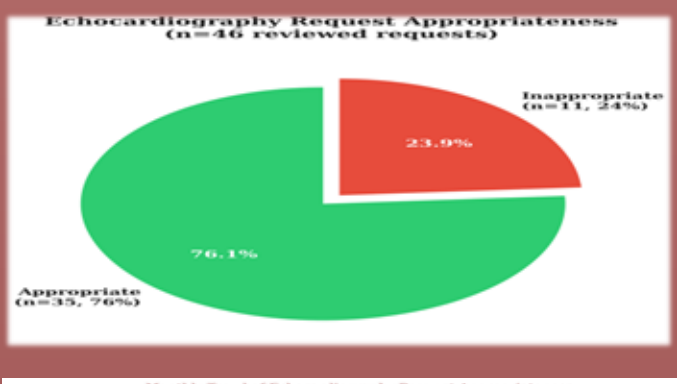
**Results**: A total of 59 echocardiography requests were collected, with 46 meeting inclusion criteria for detailed analysis out of them 76% (n=35) of reviewed requests were deemed appropriate according to BSE guidelines, 24% (n=11) did not meet established clinical indication criteria. The mean patient age was 70.4 years (SD ±15.3 years), with 67.7% of patients aged over 60 years. Male patients comprised 61% of the cohort, while female patients represented 39%.

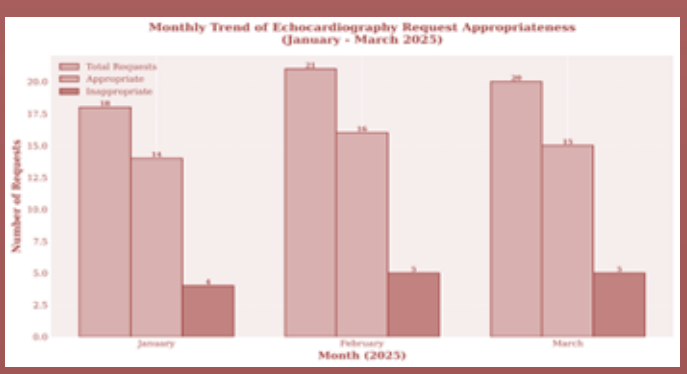
**Conclusion**:The audit demonstrates generally strong adherence to evidence-based practice, though opportunities exist for improvement. Implementation of targeted educational interventions and structured referral pathways is recommended to achieve the target compliance rate of ≥90%.


This audit identified that while most echocardiography referrals were appropriate (76%), a significant proportion were not, highlighting opportunities for improvement. Key recommendations focus on targeted education, improved access to BSE guidelines, structured referral and triage systems, and regular feedback to clinicians to enhance referral quality. System-level changes, including electronic decision support and service capacity planning, are proposed for longer-term sustainability. A re-audit is planned six months after implementation to assess improvement, with success defined by achieving an appropriateness rate of at least 90% and improved documentation quality.

1.British Society of Echocardiography. Clinical Indications for Echocardiography. BSE Guidelines. Available at: https://www.bsecho.org/common/Uploaded%20files/Education/Protocols%20and%20guidelines/Indications%20for%20echocardiography.pdf [Accessed March 2025]

2.British Society of Echocardiography. Updated Clinical Indications and Triage of Adult Transthoracic Echocardiography. BSE Guidelines. Available at: https://www.bsecho.org/Public/Education/Posters-and-guides-subpages/PUA001-triaging-posters.aspx [Accessed March 2025]

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4.Fonseca R, Pathan F, Marwick TH. Appropriateness of transthoracic echocardiography: a systematic review. Heart. 2015;101(12):974-980. doi:10.1136/heartjnl-2014-307074

5.American College of Cardiology Foundation Appropriate Use Criteria Task Force. ACCF/ASE/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography. J Am Coll Cardiol. 2011;57(9):1126-1166.

# Evaluating Electrical Stimulation Practice in Sub-Acute Stroke: A Clinical Audit

O'Sullivan, E., Quinlivan, K.
Occupational Therapy Department, St Vincent's University Hospital

## Electrical Stimulation in Stroke Rehabilitation

### Guidelines

- Recommend electrical stimulation (ES) as an adjunct to upper limb rehabilitation
- Target: Non-functional limbs or reduced strength

### Evidence

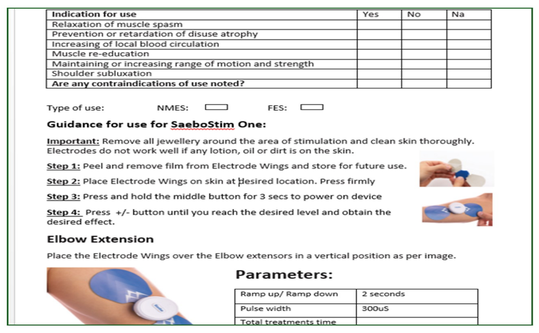
- Neuromuscular & functional ES
- Task-specific, repetitive exercise
- Management of weakness & post-stroke swelling

**Guideline & Evidence → Clinical Practice Review**

## Project Aims

- Evaluate current clinical use of ES
- Compare practice with guideline recommendations
- Identify opportunities for service improvement

# METHODOLOGY



| Indication for use | Yes | No | Na |
|---|---|---|---|
| Relaxation of muscle spasm | | | |
| Prevention or retardation of disuse atrophy | | | |
| increasing of local blood circulation | | | |
| Muscle re-education | | | |
| Maintaining or increasing range of motion and strength | | | |
| Shoulder subluxation | | | |
| Are any contraindications of use noted? | | | |

Type of use: NMES: FES:

**Guidance for use for SaeboStim One:**

**Important:** Remove all jewellery around the area of stimulation and clean skin thoroughly. Electrodes do not work well if any lotion, oil or dirt is on the skin.

**Step 1:** Peel and remove film from Electrode Wings and store for future use.

**Step 2:** Place Electrode Wings on skin at desired location. Press firmly

**Step 3:** Press and hold the middle button for 3 secs to power on device

**Step 4:** Press +/- button until you reach the desired level and obtain the desired effect.

**Elbow Extension**

Place the Electrode Wings over the Elbow extensors in a vertical position as per image.

**Parameters:**

| | |
|---|---|
| Ramp up/ Ramp down | 2 seconds |
| Pulse width | 300uS |
| Total treatments time | |

## Plan

Identified lack of electrical stimulation use

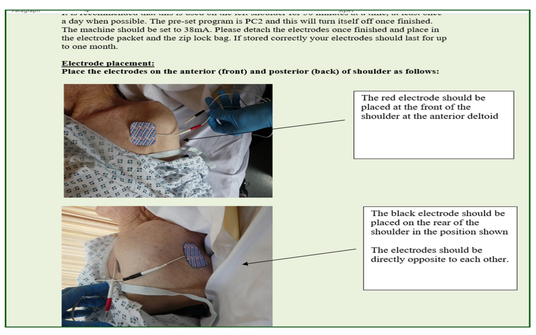
Formed national OT working group

Reviewed evidence

Completed business plan

Secured funding for devices locally

Co-ordinated national based training



a day when possible. The pre-set program is PC2 and this will turn itself off once finished. The machine should be set to 38mA. Please detach the electrodes once finished and place in the electrode packet and the zip lock bag. If stored correctly your electrodes should last for up to one month.

**Electrode placement:**
**Place the electrodes on the anterior (front) and posterior (back) of shoulder as follows:**

The red electrode should be placed at the front of the shoulder at the anterior deltoid

The black electrode should be placed on the rear of the shoulder in the position shown

The electrodes should be directly opposite to each other.

## Do

Developed ES protocols and user guides

Shared these with local services to ensure seamless transition of care

Developed ES policy locally

Integrated ES review into initial stroke upper limb assessment

Provided local staff training

Hosted national workshops

## Study

Conduct local ES audit over a 3-month period

Reviewed device use and intensity of use locally against evidence

Reviewed type if ES used locally against evidence and guidelines

Pre and post national training questionnaire


## Act

Refine protocols and education locally

Expand use of ES to other services locally

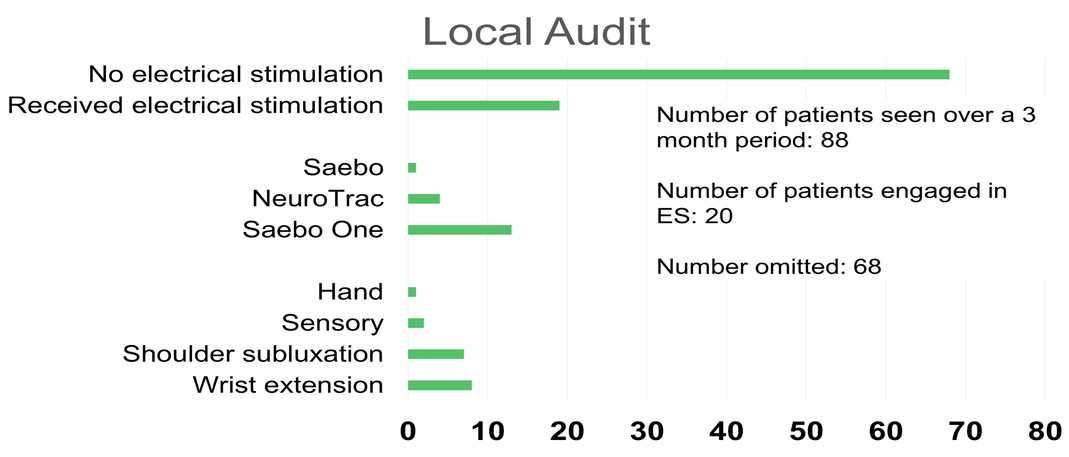
Update local guidelines and policy to reflect expansion of use

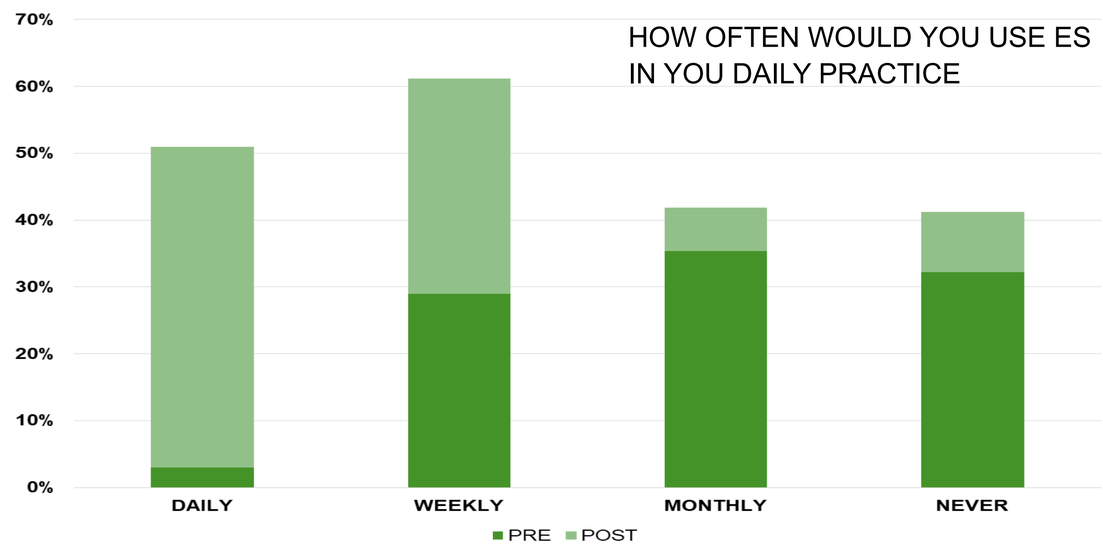
Continued national collaboration

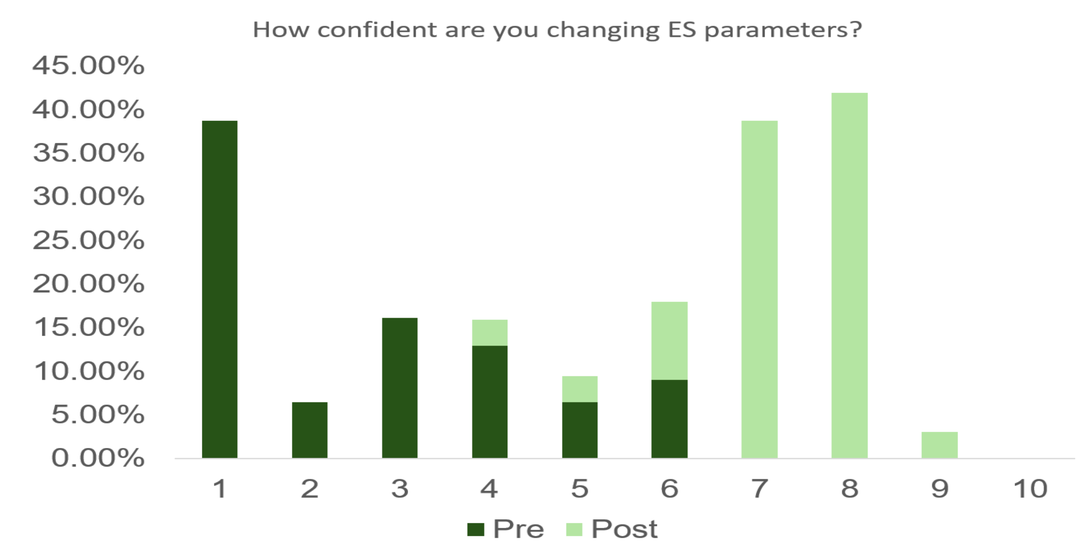
Form working group with Senior and Clinical Specialist therapists nationally

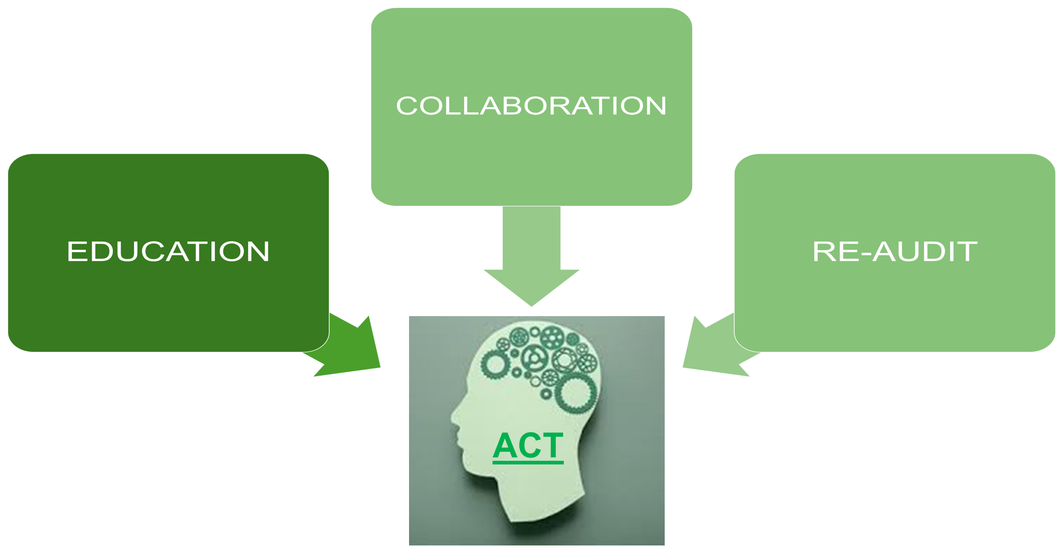
Work towards generalised census of use like that in Scotland

# RESULTS




| | | | |
|---|---|---|---|
| SVUH– 13 | RHD– 4 | NRH– 4 | CONNOLLY-1 |
| CUH– 1 | NAAS GEN– 1 | LIMERICK– 1 | TEMPLE ST– 1 |
| MATER– 1 | SACRED HEART – 1 | DROGHEDA-1 | BEAUMONT– 1 |
| UHG– 1 | CRUMLIN– 1 | | |

**SITES IN ATTENDANCE AT WORKSHOPS**

References:

Stroke Association (2023) *UK and Ireland Stroke Guidelines 2023.* London: Stroke Association. Available at: [URL] (Accessed: 26 January 2026).

National Stroke Foundation (2023) *The Australian Working Guidelines for Stroke.* Melbourne: National Stroke Foundation. Available at: [URL] (Accessed: 26 January 2026).Nascimento, A., Silva, A., and Santos, P. (2014) 'Endovascular therapies in stroke: Current evidence and future perspectives,' *Journal of Stroke and Cerebrovascular Diseases,* 23(6), pp. 1331-1337. doi:10.1016/j.jstrokecerebrovasdis.2013.11.022.

# Improving information for hip fracture patients and families
# A quality improvement initiative

Midland Regional Hospital Tullamore

## Background:

Every year in Ireland over 4,000 people experience a hip fracture. The impact of a hip fracture can be life-changing, with the right care patients can make a good recovery.

## INTRODUCTION

The aim of this quality improvement project was to improve the quality and consistency of information provided to hip fracture patients and their families in MRHT.

## Objectives:

- Assess patients understanding of hip fracture care
- Identify gaps in information provision patients receive
- Develop and implement a patient information leaflet
- Improve patient preparedness for surgery, rehabilitation and discharge

## Intervention:

Baseline audit of hip fracture patients knowledge using a structured questionnaire

Smart aim to improve patient reported adequacy of information within 12 months

PDSA cycles used to design, test and refine a locally developed patient information leaflet

## RECOMMENDATIONS & CONCLUSION

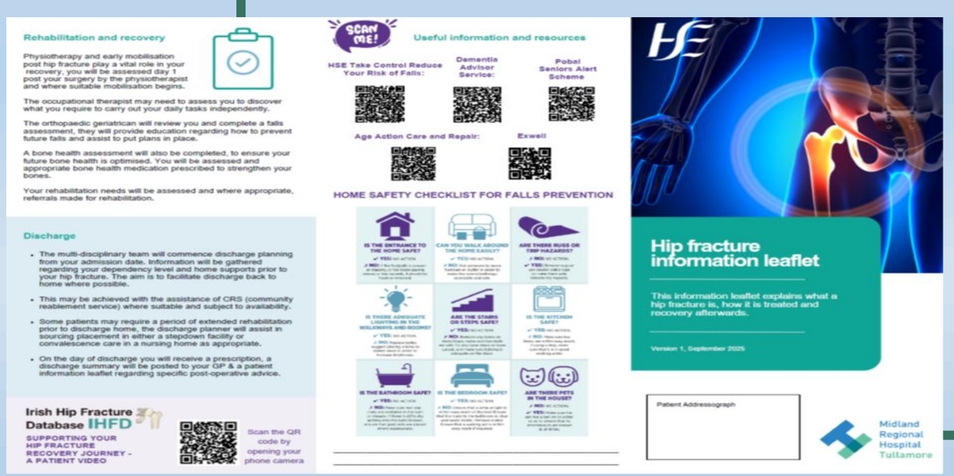
Audit identified significant variation regarding information provided to patients

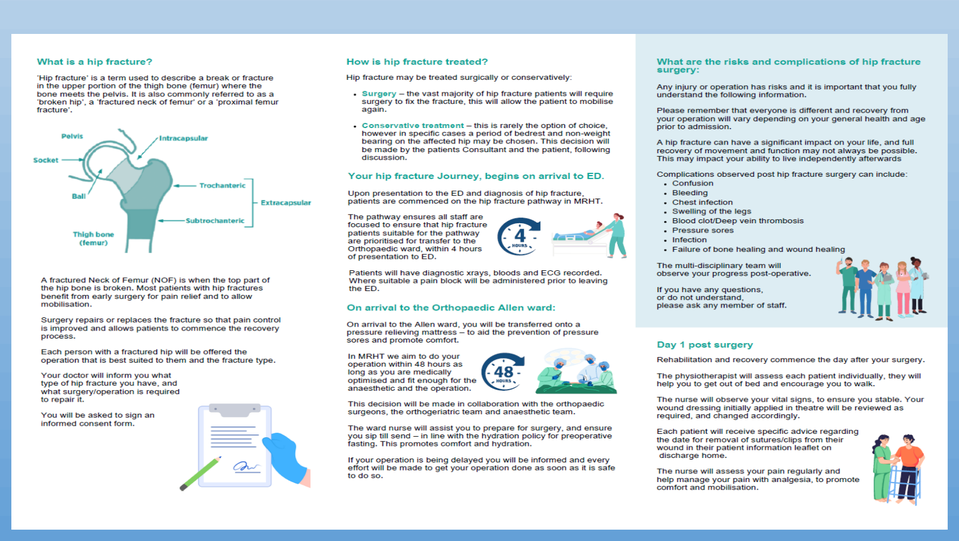
This variation guided the formation of the patient information leaflet

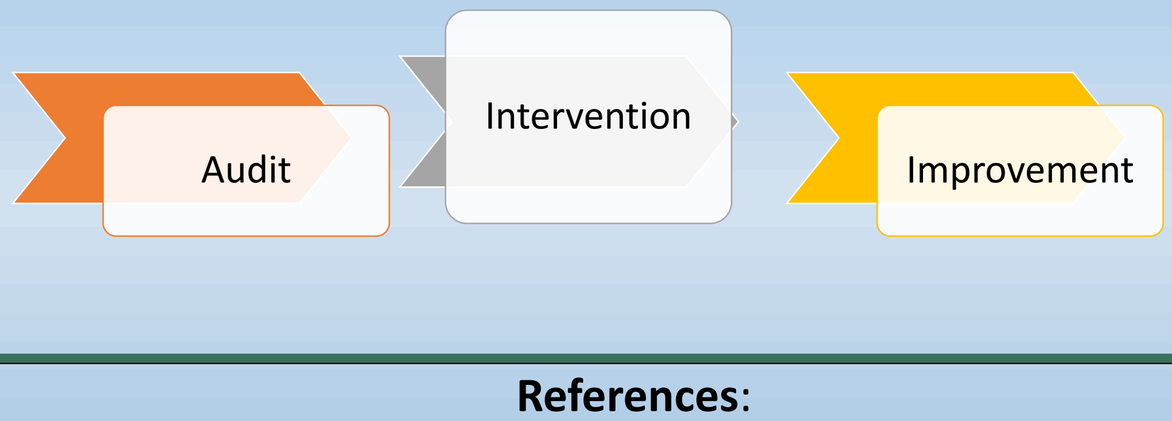
The new information leaflet improved consistency and clarity of information delivery

The new information leaflet provides enhanced patient and family understanding of surgery and recovery. Rehabilitation expectations, falls prevention and community supports.

A structured quality improvement approach enabled the successful development of a patient centred hip fracture information leaflet.




## References:


Ferris, H., Brent, L. and Sorenson, J. (2022a) Cost of hospitalisation for hip fracture – finding from the hip fracture database. *Osteoporosis International*, 33(5), pp. 1057-1065.

National Office of Clinical Audit (2024) Irish Hip Fracture Database National Report 2024. Dublin: National Office of Clinical Audit.

# Service evaluation of the dental department and the shared care for children with inherited bleeding disorders at CHI Crumlin

## PROJECT DETAILS

Service evaluation of the dental department and haematology shared care for benign haematology patients

Barry L[1], Nolan B[2], Ahmed S[2], Kenny K[1], FitzGerald K[1]

1 CHI at Crumlin, Dental Department
2 CHI at Crumlin, Haematology Department

## AIMS & OBJECTIVES

**Aim**: to quantify the number of paediatric patients with moderate to severe bleeding disorders assessed by the dental team

**Objective**: to assess if patients were directed to the appropriate dental care pathway

## BACKGROUND

- Children with benign haematological conditions are at increased risk of and from oral disease due to impaired haemostasis
- In Children's Health Ireland (CHI) at Crumlin, dental care for children with inherited bleeding disorders is delivered through a shared care model between the dental and haematology teams
- Preventative dental care and coordinated management between these services is essential to minimise bleeding risk and ensure safe dental treatment
- Growing service demands and increasing clinical complexity highlight the need to evaluate this model

## METHODS SUMMARY

**Retrospective data collection** was completed using Indici, an electronic patient record and national database

**Time period:**
- November 2011 to November 2024

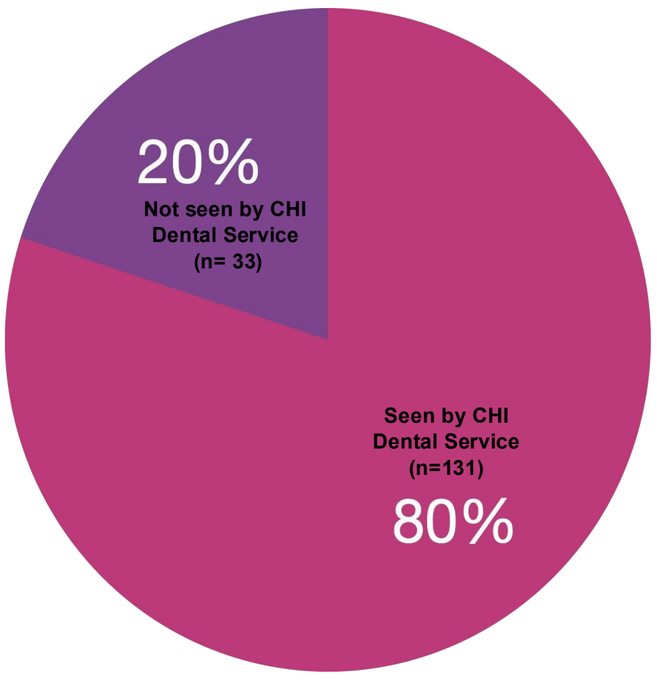
**Inclusion criteria**:
- Moderate and severe bleeding disorder
- Haematology Consultant requested specialist paediatric dental assessment

**Process**
Patient appointments were reviewed on iPIMS systems and letters checked on G2Speech System

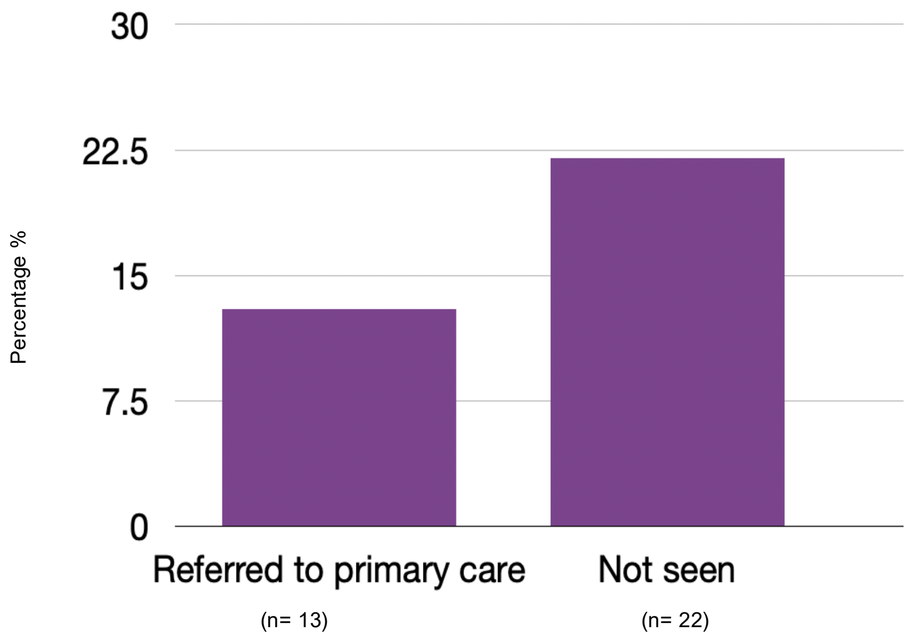
**Data Management**
- Data was entered onto an Excel spreadsheet
- Descriptive statistical analysis was undertaken

## KEY RESULTS

**Total number of patients whose data was collected (n=164)**




**Patients not seen by Dental Department in CHI Crumlin**




- One hundred and sixty four requests for dental assessment were made
- Eighty percent of patients were assessed by the dental service
- Of the remaining 20%: 40% were referred to primary care dental services, while the other 60% were not assessed or referred by this date
- 13.4% of the total cohort had neither been seen by the CHI Dental Service nor referred elsewhere
- Of note 29 of the 131 patients seen did not have letters, referred out to be monitored by the community, this is likely related to needing treatment by the CHI Dental Department or requiring follow up in CHI Dental Department
- This indicated that one fifth of children who had been referred by the benign haematology team had not been seen. Service development was required to improve this number

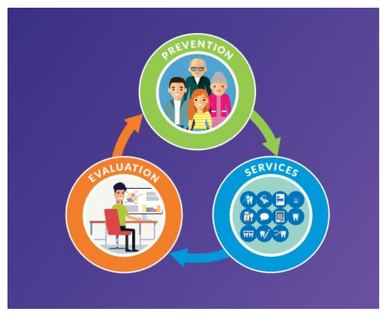
## SUPPLEMENTARY INFORMATION

**Interventions in place to improve rate of assessment:**

- The dental team now attends weekly benign haematology multidisciplinary team meetings,
- A new dental referral tab on the *Indici* database has been developed for more efficient referrals between departments
- Dedicated dental outpatient appointments have been introduced on Monday afternoons, enabling same-day dental assessment for patients attending benign haematology clinics at CHI Crumlin

**Context**

- *Smile agus Slainte* is the National Oral Health Policy. It highlights the 'Dental Home' concept.
- This states that children should have primary care dentist close to home, with specific pathways that allow those with additional needs access tertiary care when required




**Future Plans**

- To ensure that 100% of children with moderate to severe bleeding disorders receive timely dental assessment and treatment when required
- Repeat this audit to determine if the interventions have improved the rate of assessment
- Educate community-based dentists about dental management of children with inherited bleeding disorders, particularly in how to prescribe tranexamic acid.

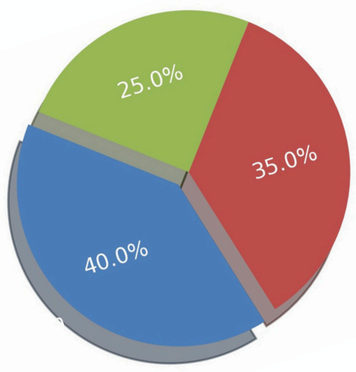
# Optimising Nutrition After Fragility Fractures: A Nursing Perspective

NMHS32140 - Course in Orthopaedic Nursing ; Marie Helen Y. Baniaga; Student no.: 25227717

## BACKGROUND

Fragility fractures in olderadults are a major healthcare burden, commonly associated with malnutrition, prolonged hospital stays, and increased mortality. Studies show 25– 66% of hip fracture patients are nutritionally at risk (Bell et al., 2020; Volkert et al., 2019). Malnutrition contributes to pressure ulcers, infections, delayed recovery, and is prevalent across care settings. Early screening and coordinated nutrition strategies are essential for improving recovery outcomes.

## KEY NUTRITIONAL RISKS




- 2/3 malnourished by discharge
- 25% on admission (HIQA, 2015)
- Low in protein, Vitamin D, Calcium
- Sarcopenia & frailty slow recovery
- Risk raise complications & mortality

## SCREENING & ASSESSMENT

### When to Screen

- Screen all fracture patients >65 yrs on admission.
- Ideally within 24 hours.

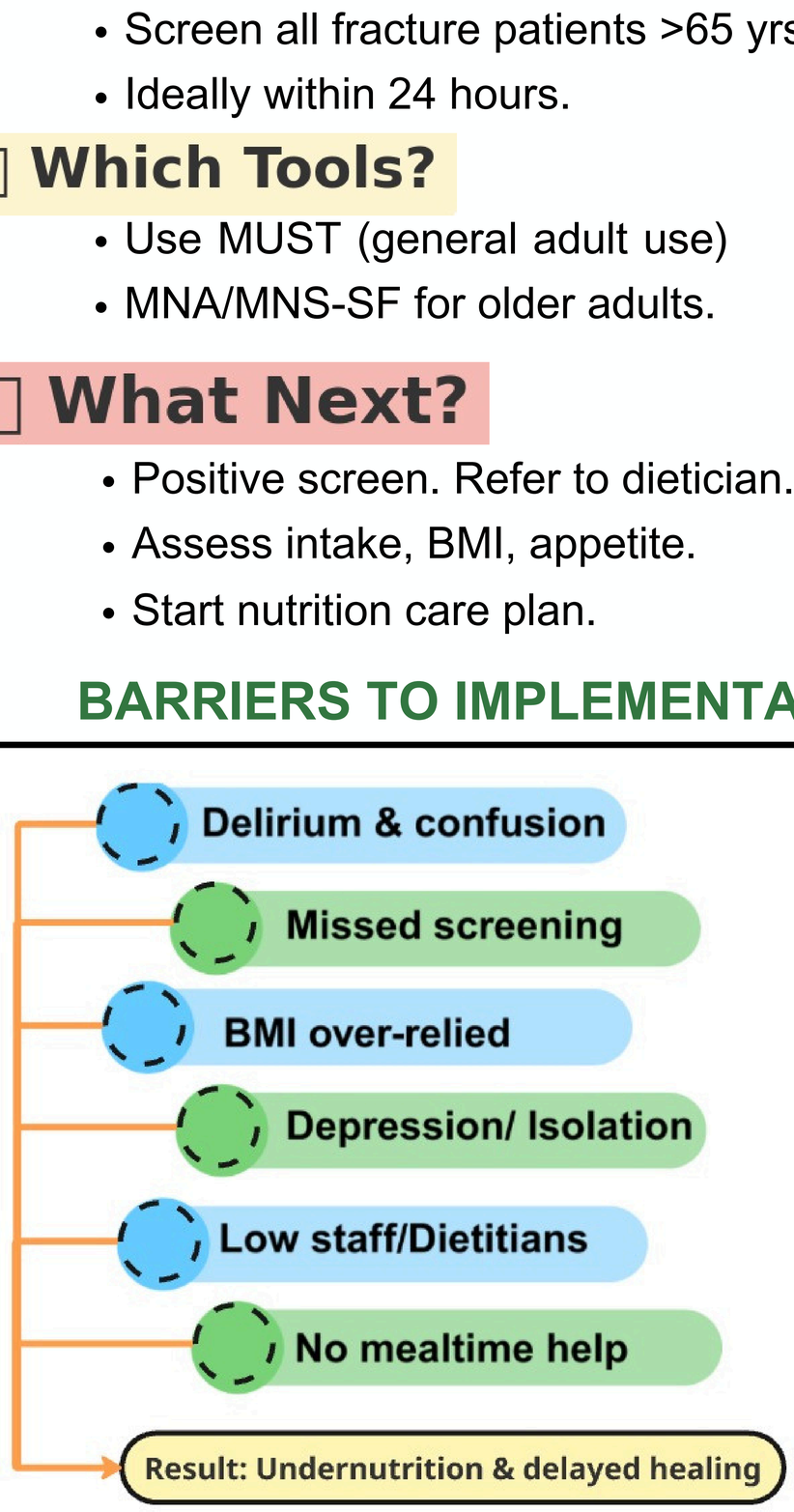
### Which Tools?

- Use MUST (general adult use)
- MNA/MNS-SF for older adults.

### What Next?

- Positive screen. Refer to dietician.
- Assess intake, BMI, appetite.
- Start nutrition care plan.

## BARRIERS TO IMPLEMENTATION




## EVIDENCE-BASE INTERVENTIONS

**~Optimizefood intake~**

High-protein, high-calorie meals & snacks.
Small, frequent eating; mealtime support.
(*Volkert et.al., 2019*)

**~Add oral supplements~**

Oral nutritional support for poor intake.
Reduces complications in older adults.
(*Bell et al., 2020*)

**~Vitamin D & Calcium~**

Start ≥800 IU Vit D & 1,000–1,200 mg Ca.
Correct deficiencies (e.g., B12, iron)
(*NICE, 2017; HSE, 2020*)

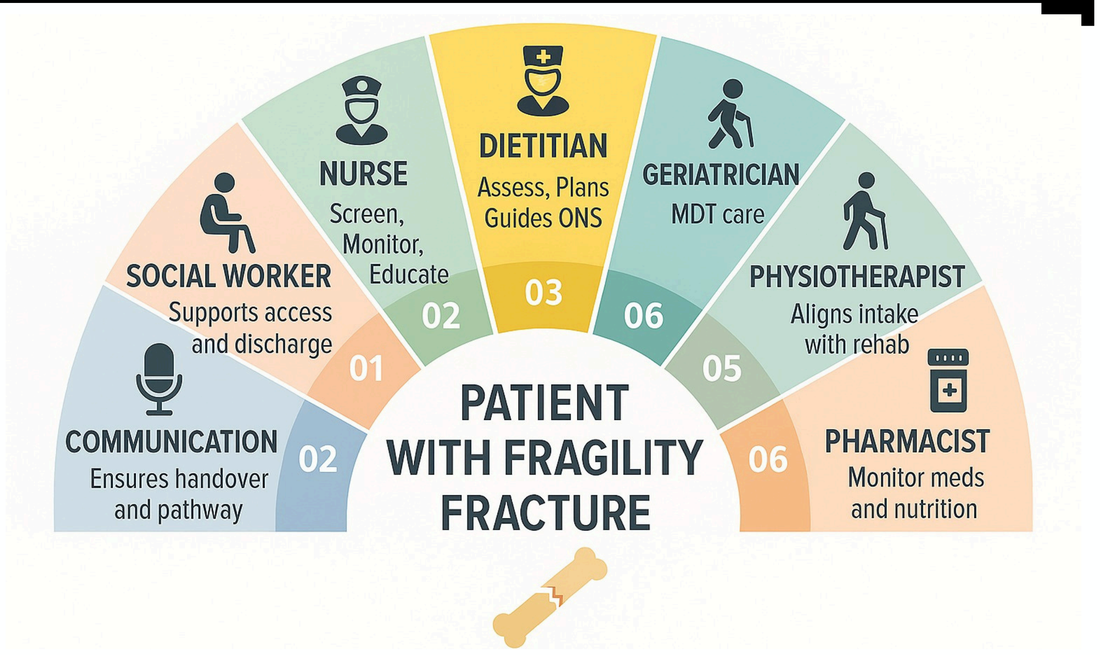
**~Nurse-Led Actions~**

Screen early (MUST/MNA)
Assist and educate.
(*DOH, 2020*)

**~Rehab Integration~**

Nutrition enable rehab success.
Align with physiological/OT plan.
(*Franz et al., 2023*)

## MULTIDISCIPLINARY COLLABORATION




## KEY TAKEAWAYS

**EARLY ACTION:**
Screeningwith MUST/MNA allows timely support (Kaiser et al., 2010).

**NURSE LEADERSHIP:**
Screening, monitoring, and nutrition education.

**TEAM WORK:**
Disciplinary collaboration improves outcomes.

**PREVALENCE:**
Malnutrition impaires recovery in fracture patients (Bell et al., 2020; HIQA, 2015).

# ICU Delirium: Are We Over It Yet?

## A Multi-Method Audit of Assessment, Risk Factors, Outcomes and Management Practices of Delirium in the Intensive Care Unit

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta

An Academic Partner of Trinity College Dublin

Tamas Tiszai-Szucs[1], Melanie Ryberg[2], Binila Kurian[3], Varsha Rai[4], Krishna Bogala[4], Ayesha Rida[4], Huma Rukhsar[4], Adnan Iqbal[4].

1 Consultant Intensivist, Clinical Quality and Audit Lead; 2 Principal Specialist Clinical Psychologist; 3 Clinical Facilitator; 4 Non-consultant hospital doctors. Dept. of Anaesthesiology.

## Background

Delirium is a common condition in the Intensive Care Unit (ICU) settings and is associated with adverse outcomes, including longer hospital stays, increased mortality, and long-term cognitive decline. However, identification and management practices remain highly variable. This study examines the prevalence, risk factors, and clinical consequences of delirium, with a focus on management patterns and pain trends in the Intensive Care Unit of Tallaght University Hospital.

## Key Findings

### Aim

**This multi-method audit aimed to assess the accuracy of delirium detection, explore risk factors, evaluate clinical responses, and identify opportunities for quality improvement.**

### Methodology of Audit

Three audits were conducted as part of a broader Green Belt Lean Six Sigma quality improvement project:

1. A prospective observational audit (n = 22) evaluated nurse-led neurocognitive assessments, including the Richmond Agitation-Sedation Scale (RASS), Confusion Assessment Method for the ICU (CAM-ICU), pain score and neurological examination.
2. A retrospective analysis (n = 84) reviewed the prevalence, risk factors, documentation, and outcomes of delirium in patients admitted consecutively in June 2024.
3. A clinician survey (n = 16) examined physician awareness, attitudes, and practices surrounding delirium management.

### Assessment and Prevalence

- Delirium monitoring was primarily nurse-led, with bedside nurses achieving RASS scoring accuracy of 77.3% compared to clinical facilitators. In contrast, CAM-ICU assessments were accurate in only 63.6% of cases.
- Physicians documented RASS scores in daily progress notes in only 42% of cases. Physician attention was greater in hyperactive cases, where delirium was reported in 57% versus just 14% of non-hyperactive presentations.
  - 50% (42/84) developed delirium based on nurse-led clinical exam.
  - 25% (21/84) had hyperactive delirium, 50% of delirium cases.

### Risk Factors and Outcomes

- Delirious patients had significantly higher illness severity on admission, with a median APACHE II score of 17 compared to 13 in non-delirious patients (p = 0.014).
- They also required longer vasopressor support (median 2 days vs 1 day, p = 0.009).
- There was a trend toward increased ventilator days among the delirious group (mean 3.3 vs 1.2 days, p = 0.08), suggesting more prolonged need for mechanical support.
- Additionally, prior benzodiazepine use was more common in delirious patients (19% vs 7%, p = 0.11), and a history of alcohol abuse also appeared slightly more frequent, although neither reached statistical significance.

| Outcomes | ICU LOS (Median, IQR) | ICU Mortality |
|---|---|---|
| No delirium (n=42) | 1.94 days (0.97–4.90) | 11.9% (5/42) |
| Delirium (any subtype) (n=42) | 7.93 days (2.9–17.4) | 21.4% (9/42) |
| ❖ Hyperactive or mixed (n=21) | 9.88 days (4.2–18.8) | 19.0% (4/21) |
| ❖ Non-hyperactive (n=21) | 4.83 days (2.4–10.1) | 23.8% (5/21) |

Klouwenberg, P. M. C. K., Zaal, I. J., Spitoni, C., Ong, D. S. Y., van der Kooi, A. W., Bonten, M. J. M., Slooter, A. J. C., & Cremer, O. L. (2014). The attributable mortality of delirium in critically ill patients: Prospective cohort study. *BMJ, 349*, g6652. https://doi.org/10.1136/bmj.g6652

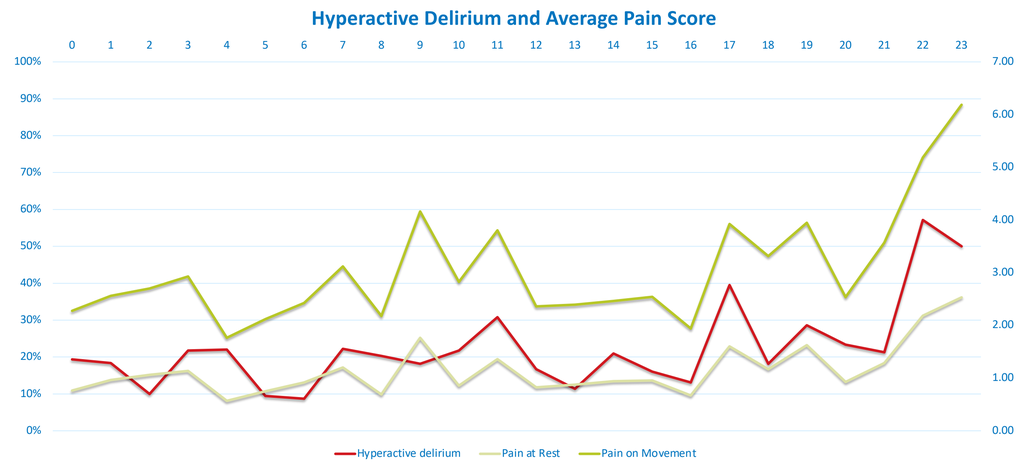
Pandharipande, P. P., Girard, T. D., Jackson, J. C., Morandi, A., Thompson, J. L., Pun, B. T., ... & Ely, E. W. (2013). Long-term cognitive impairment after critical illness. *New England Journal of Medicine, 369*(14), 1306–1316. https://doi.org/10.1056/NEJMoa1301372

Devlin, J. W., Fong, J. J., Howard, E. P., Skrobik, Y., Klein, J., Drouin, M., & Fraser, G. L. (2008). Assessment of delirium in the intensive care unit: Nursing practices and perceptions. *American Journal of Critical Care, 17*(6), 555–565. https://doi.org/10.4037/ajcc2008.17.6.555

Tallaght University Hospital

### Pain and Delirium

- Self-reported pain during movement was frequently elevated (5–6/10) and showed a strong temporal correlation with peaks in hyperactive delirium, particularly during the evening (see figure below).
- These findings suggest that inadequate pain control, especially during routine care, may contribute to agitation and potentially trigger or exacerbate hyperactive delirium in vulnerable ICU patients.
- Interestingly, overall pain scores were paradoxically lower in delirious patients, likely reflecting more profound sedation or impaired reporting, underscoring the complexity of pain-delirium interactions.




### Management

- Hyperactive delirium was more likely to be treated pharmacologically, with 57% of patients given sedatives or antipsychotics compared to 24% of those with non-hyperactive forms.
- Benzodiazepines (e.g., PRN lorazepam) were used in 43% of hyperactive cases, over 60% of which were deemed unjustified based on clinical indicators, versus 24% in non-hyperactive patients.
- Non-pharmacological strategies, such as sleep protocols or reorientation, were underdocumented in daily physician progress notes across both groups—only 23.8% of hyperactive and 14.3% of non-hyperactive patients received such interventions, despite nursing staff anecdotally reporting their widespread use.
- Overall, assessment and management practices based on physician documentations showed high variability, highlighting inconsistent adherence to evidence-based guidelines and the need for standardised protocols.

- **While delirium is routinely screened by nursing staff using standardised tools in our ICU, the accuracy of that assessment is suboptimal, with consequences for management and outcomes.**
- **Pharmacological treatment dominates current practice in hyperactive and mixed delirium, with a high degree of variability, while non-pharmacological strategies remain underreported.**
- **The findings warrant the development of a standardised delirium management protocol. Clinicians should prioritise early detection through consistent input from nurses and physicians, judicious use of sedatives, and structured non-pharmacological care pathways.**

People's Needs Defining Change
HEALTH SERVICES CHANGE GUIDE

www.hse.ie/changeguide

# A quality improvement process in the management and outcomes of patients with confirmed Cauda Equina Syndrome (CES) in the national neurosurgical centre, Beaumont Hospital (BH).

**Authors: : L Byrne, C Treanor, D Nolan, H Gomaa, F Kinsella, A Dooley, S Hanratty, S O'Brien King, D O'Brien**

## Introduction

- Beaumont Hospital is the national neurosurgical centre responsible for delivering emergency and elective spinal neurosurgical intervention
- Cauda Equina Syndrome (CES) is a spinal surgical emergency with potential for longterm sequelae and healthcare service use
- In 2021, a UK review highlighted variation in management and outcomes of CES patients prompting the development of a national CES pathway by the Get it Right First Time (GIRFT) programme.
- There was no benchmarking of the care of patients who underwent emergency surgery for Cauda Equina Syndrome (CES) in Beaumont Hospital
- A standardised audit tool was established based on GIRFT recommendations and an audit carried out highlighting inconsistency in the quality of assessment and care received by this patient cohort.
- The results were presented to the neurosurgical team.

## Change Framework


## Engagement

People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff

- A CES multi-stakeholder working group was established
- Specific audit findings were targeted as areas for improvement
- Monthly progress meetings took place to monitor progress
- The work of the group was represented to the neurosurgical team

## DEFINE

The working group produced the following to address agreed targets for improvement:

- A standardised audit tool was established based on GIRFT recommendations for annual audit purposes.
- A new standard of care (SOC) was developed with a standardised assessment tool
- An educational presentation for staff was developed and delivered

## DESIGN

- A PDSA cycle was completed involving an audit of implementation over a 10 week period (n=4 CES cases)
- This highlighted that the audit tool was fit for purpose, capturing all appropriate data and metrics.
- There was minimal uptake of the assessment form and adoption of the proposed SOP
- An analysis of the barriers to adoption was completed with the feedback from this implemented

## DELIVER

- The findings and recommendations were well received but not widely implemented
- To address this, we have devised to proposed next steps:
- Present findings of re-audit of implementation to neurosurg team at MDM
- CES as standing CPD item for neurosurgical team with online presentation available for staff CPD to promote meaningful and sustained change in the management of CES
- Re-audit implementation over next 2 months

## Outcomes

- CES remains a challenging condition to manage given the emergency nature of the condition
- This area remains a standing item for improvement in the neurosurgical service with ongoing efforts to address shortcomings, however, there is clear guidance now available within the unit
- The challenge remains adoption to progress towards widespread and sustained change
- We have also engaged with Spinal Injuries Ireland in relation to this area to engage a public and patient perspective

Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES

**For more information contact us at the National Neurosurgical Centre, Beaumont Hospital**

**E: laurabyrne6@beaumont.ie**

**1.References:** GIRFT (2023) *Spinal Surgery: National Suspected Cauda Equina Syndrome (CES) Pathway, https://gettingitrightfirsttime.co.uk*. Available at: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2024/07/National-Suspected-Cauda-Equina-Pathway-Updated-July-2024.pdf (Accessed: 30 January 2025).
2.HSE (2024) *HSE national clinical guideline for cauda equina syndrome, Corporate*. Available at: https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-national-clinical-guideline-for-cauda-equina-syndrome/ (Accessed: 30 January 2025).

# Mater Spinal Virtual Interface Clinic

Stephen O' Rourke (1), Alan Seddon (1), Elaine Maughan (1), Mr. Marcus Timlin (1)(2)
Mater Misericordiae University Hospital Dublin (1)
Cappagh National Orthopaedic Hospital Dublin (2)

## Methodology

The Physiotherapy-led MSK Triage initiative, established in 2012 as a partnership between the National Clinical Programmes for Trauma and Orthopaedic Surgery and Rheumatology, was developed to address increasing demand for orthopaedic and rheumatology outpatient services.

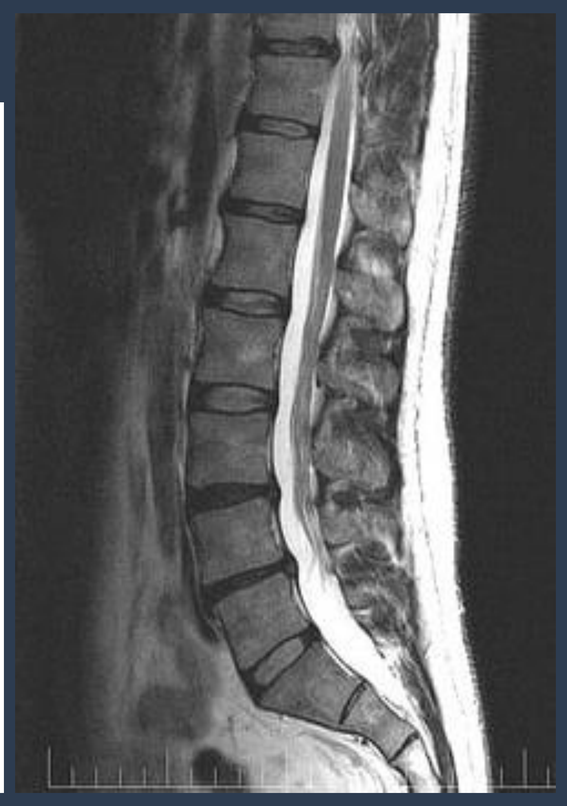
Clinical Specialist Physiotherapists (CSPs), working under the clinical governance of orthopaedic and/or rheumatology consultants, triage and manage patients referred to orthopaedic or rheumatology waiting lists who are unlikely to require consultant intervention.

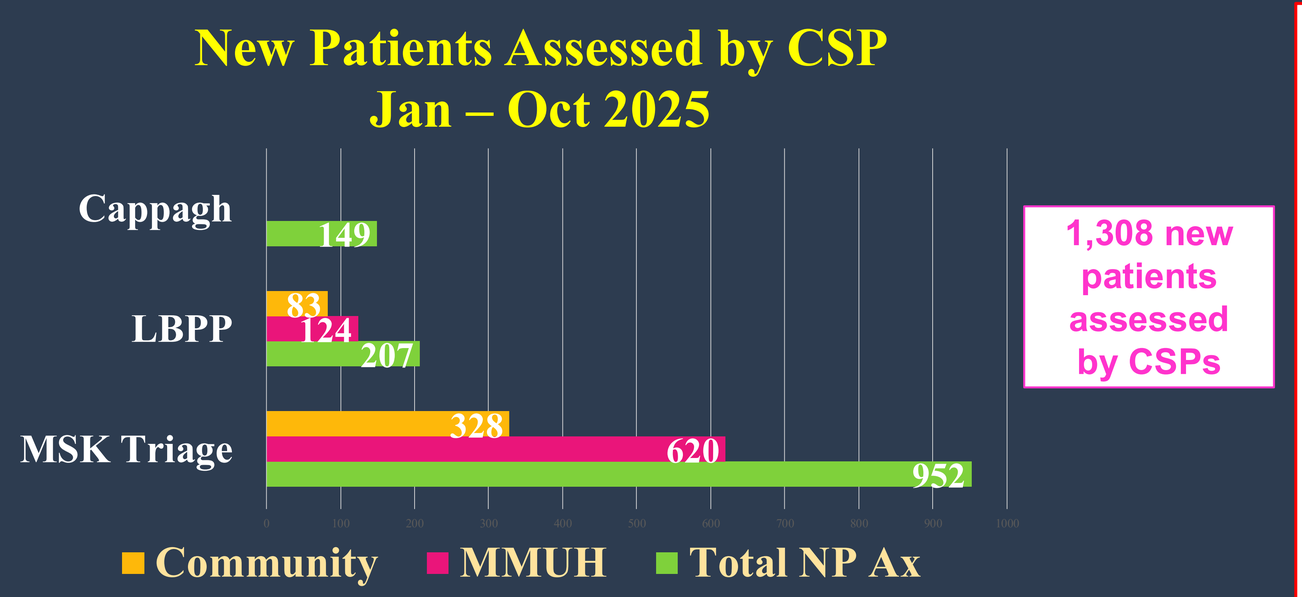
The National Integrated Low Back Pain Pathway (NiLBP), developed in collaboration with the HSE's Modernised Care Pathways Programme in 2023, aims to improve access for patients not requiring surgical care. Mater Misericordiae University Hospital and University Hospital Waterford were selected as pilot sites for this pathway.

The Interface Clinic is a key component of the MSK Triage and Low Back Pain Pathway service, providing timely access to consultant orthopaedic input for case discussion and management planning, thereby improving care efficiency.

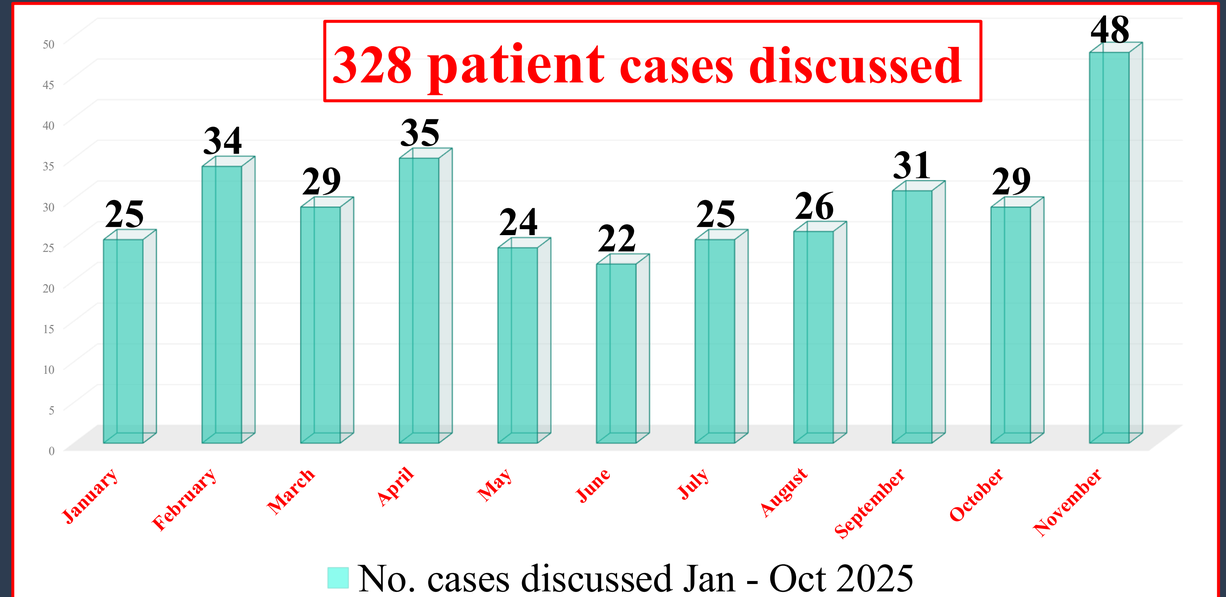
## Results

- **328** patients managed via Virtual Consultant Interface
- **1,308** new patient spinal assessments across CSPs in three sites.
- **25%** patients discussed at to Interface Clinic
- **55%** patients discussed required referral for injection.
- **75%** patients managed independently.

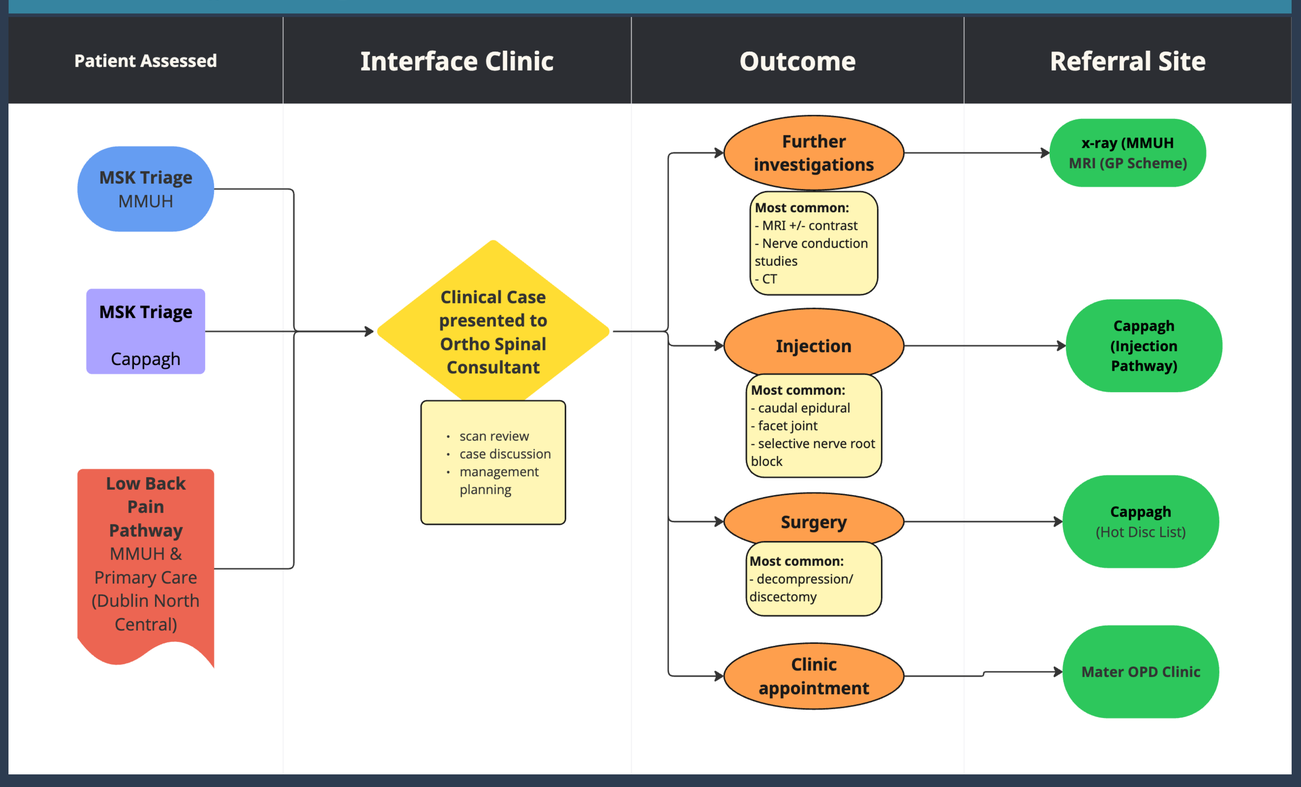


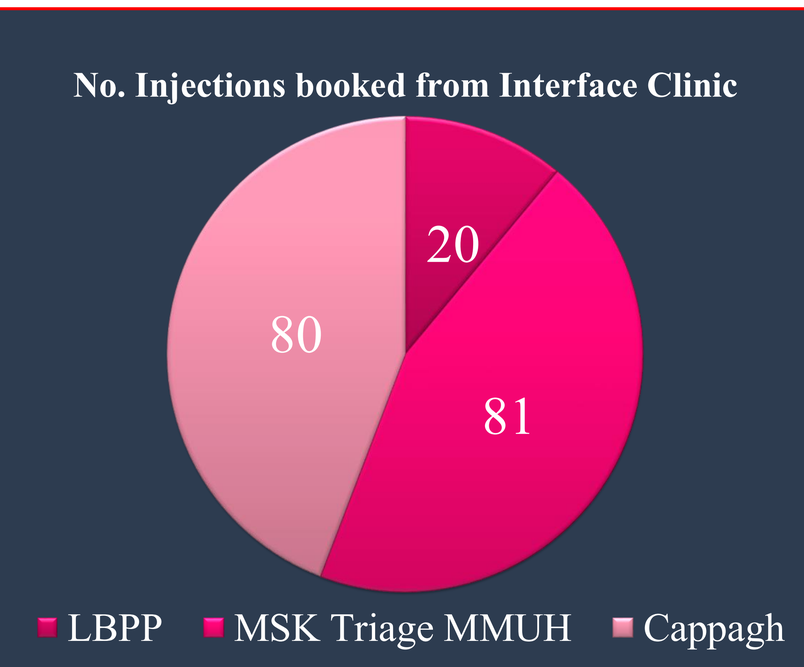



1,308 new patients assessed by CSPs




## Process Map – Integrated Multi Site Services




55% patients discussed referral for spinal injection.

14% of patients assessed referred for injection.

## Interface Clinic

The **Virtual Spinal Interface Clinic** was developed as part of the MSK Triage service. In 2024, it expanded to include Cappagh Hospital, developing multi site MSK Triage service integration. It is a scheduled monthly meeting (virtual/in-person) with both teams and an orthopaedic spinal consultant. At this meeting, clinical cases and imaging are jointly reviewed, allowing for a collaborative and comprehensive assessment. Together, the team formulates a personalised management plan for each patient. Onward referral for diagnostics, pain management or surgical treatment is planned from this Interface clinic. For those patients requiring surgical intervention, there is a **rapid access spine pathway** established at the National Orthopaedic Hospital, Cappagh. The Interface clinic is also attended by various other national sites and community physiotherapy teams who attend virtually for educational purposes.

**328** clinic cases have been discussed and managed via the **Virtual Spinal Interface Clinic** in 2025 from January – October from **MSK Triage MMUH, MSK Triage Cappagh & The Low Back Pain Pathway MMUH.**

## Interface Clinic Results Review

- 8.7% of patients assessed by CSPs in the LBPP & MSK Triage service in the Mater Hospital required an injection, arrange via virtual consultation with an orthopaedic spinal consultant.
- 91.3% were managed independently by CSPs under their services.
- 30% of patients discussed at Interface by MMUH CSPs required an injection.
- 6% of injections booked from Interface were from the Low Back Pain Pathway (LBPP)
- 24% of injections booked from Interface were from MSK Triage MMUH service.

## Acknowledgements

Ruth Kiely, Dr. Sarah Casserley & Niamh Keane. Physiotherapy Management teams at both sites. Community partners including Joanne Finn and Naomi Lyng. Admin staff. MSK Triage and LBPP admin team on the ground. Senior Physiotherapists Diarmuid O Conluain & Ciaran Beglan (MMUH).

# A prospective re-audit on insulin prescribing and administration practices in a university teaching hospital

Diana Hogan-Murphy[1], Deirdre Cunningham[1], Fiona Nolan[1], Aine Cunningham[2], John Given[1], Michael C. Dennedy[1,2], Laurence Egan[1,2], Hesham Almaheni[1],Grace Mannion[1],Ridhwaan Salehmohamed[1]

1. University Hospital Galway; 2. University of Galway

## BACKGROUND

Injectable insulins are high-alert critical medicines which can cause significant patient harm. These preparations have been identified as a significant medication safety concern in Galway University Hospitals (GUH) and are one of the most frequently reported medication incidents in Ireland. The first hospital-wide insulin audit in GUH was conducted in 2022 to evaluate insulin practices and develop quality improvements to optimise patient care. Interventions implemented include: the appointment of a senior pharmacist with a special interest in diabetes (June 2022); an updated insulin and glucose monitoring record (October 2024, previous edition June 2022); development and implementation of an eLearning module for the safe use of high-alert medications specific to GUH which includes a section on insulin (March 2023); continuous education on appropriate insulin use for staff, students, patients and carers; updated/newly approved guidelines; use of hospital screens and social media to disseminate pertinent information; and promotion of medication incident reporting.

The aim was to conduct a similar audit in order to assess performance since the previous audits, develop further quality improvement initiatives as needed, and encourage participation of all Irish hospitals in conducting a standardised annual insulin audit by disseminating results and promoting benefits.

## METHODS

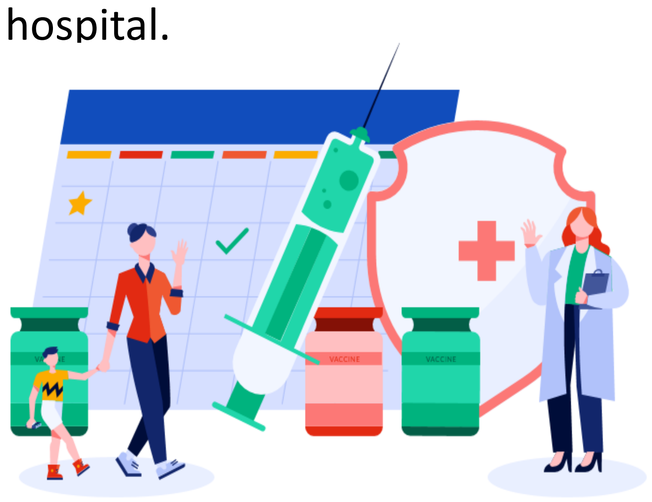
This audit was conducted over one day in May 2025 on 24 wards by 25 interprofessional data collectors and comprised inpatients prescribed/administered insulin in GUH for the previous 72 hours. The audit protocol and tool were approved by the local Clinical Audit Committee, piloted with four inpatients, and communicated to all data collectors prior to commencement.
All generated data was anonymous and securely stored. Data analysis was carried out by three independent researchers to confirm reliability of results.

## RESULTS

575 inpatients were reviewed, of which 18% had diabetes and 7% were prescribed insulin. Prescribing errors comprised 63% of records, similar to 2024 but representing a substantial improvement from 80% in 2022. Administration errors were identified in 84% of records, consistent with previous audits. Five percent of insulin orders were not signed by a prescriber, demonstrating a marked improvement from 20% the previous year. Over nine out of ten prescribers clearly documented the correct insulin, dose and administration times and the majority recorded prescriber identification (MCRN, bleep, or name), supporting safe practices and traceable prescribing practices. Failure to document administration times was noted in 42% of cases, similar to previous audits. Insulin was not double-checked by a second independent individual in 11% of cases, compared to 30% in 2022.

## DISCUSSION

Results show ongoing improvement in prescribing accuracy and documentation, particularly the significant reduction in unsigned insulin orders. Administration errors remain high, highlighting the need for continued education, reinforcement of double-checking practices, and stronger interdisciplinary collaboration. High-leverage strategies such as electronic prescribing are a current consideration to standardise practices. Regular audits with quality improvements continue to play an important role in promoting safe insulin use and maintaining a culture of medication safety within the hospital.



All aspects of this review are transferable to other hospitals. Disseminating results and promoting transferable benefits should encourage participation of all Irish hospitals to conduct a standardised national annual insulin audit to improve patient care.

**Acknowledgements**
Many thanks to all data collectors.

# Use of outcome measures for Return to Sport in paediatric physiotherapy: A Retrospective Observational Study.

PRESENTED AT:


1. Sheridan N.1, Keating L.1, Blake C.2, Kelly E. 2, O'Toole P. 2, Donnelly T. 2 O'Malley G.1,2

1.RCSI School of Physiotherapy

2. Children's Health Ireland at Temple St.


## Introduction

Rehabilitation enables patients to return to their previous level of function

"Return to Sport" (RTS) refers to a structured, criteria-based process enabling an athlete to resume their pre-injury level of sports participation.

Physiotherapists routinely measure outcomes which are impairment-based (relating to movement, strength, balance)

Measuring progress to the point of return to sport requires additional tools.

Time and space are recognised challenges in CHI for using objective return to sport measurement tools consistently.

## Purpose

To identify gaps in "Return to Sport" service provision at Children's Health Ireland and describe utilisation of evidence based sports injury prevention programmes in children/ adolescents after orthopaedic surgery or musculoskeletal trauma.

## Participants

Children / adolescents over the age of 10 years.

Post lower acute lower limb injury or lower limb orthopaedic surgery.

They did attend their 1st physiotherapy appointment.

Referred for physiotherapy between 1 Jan 2022 and 31 Dec 2022 to CHI physiotherapy services.

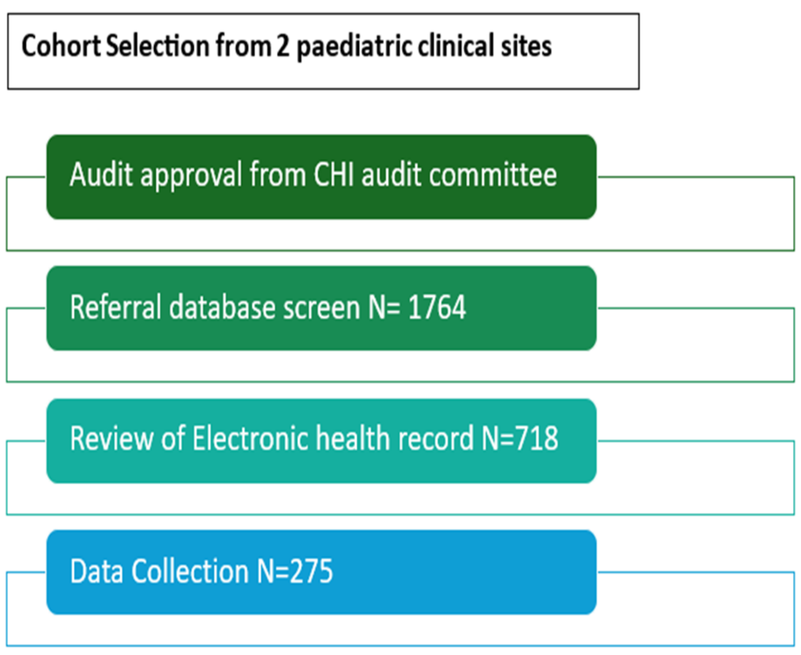
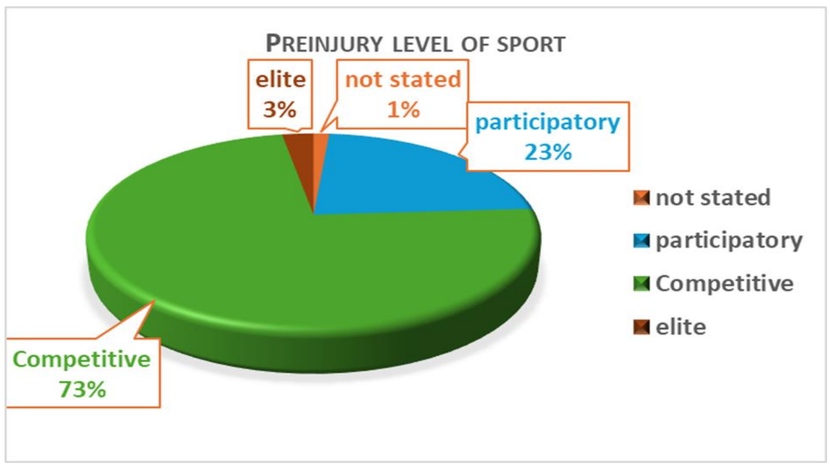



Figure 1: represents patient cohort selection process

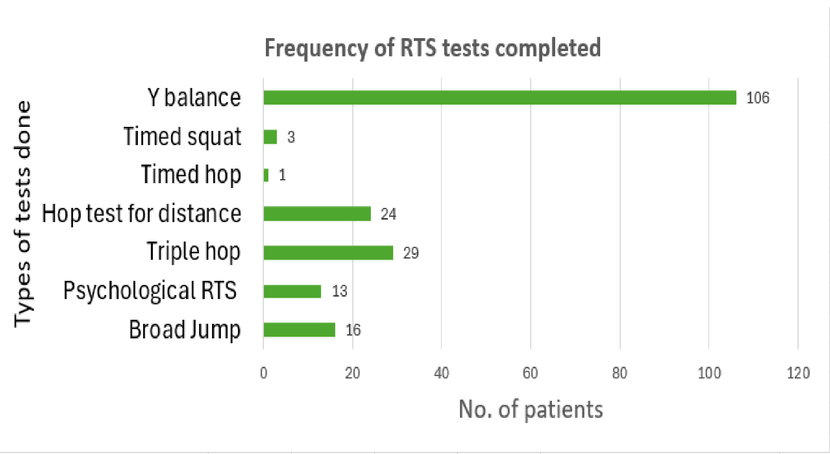
## Methods

1. Audit approval from clinical audit committee in Children's Health Ireland ( CA23-10-01).
2. Cohort selection from 2 clinical sites in Children's Health Ireland from referral data base N=1764 .
3. Application of inclusion/ exclusion criteria N= 275
4. Data extraction from electronic data management system.
5. Data analysis using Stata
6. Regression analysis to examine effect of confounding factors.

## Results




.Figure 2 Preinjury level of sport of participants




.Figure 3: Return to sport tests completed

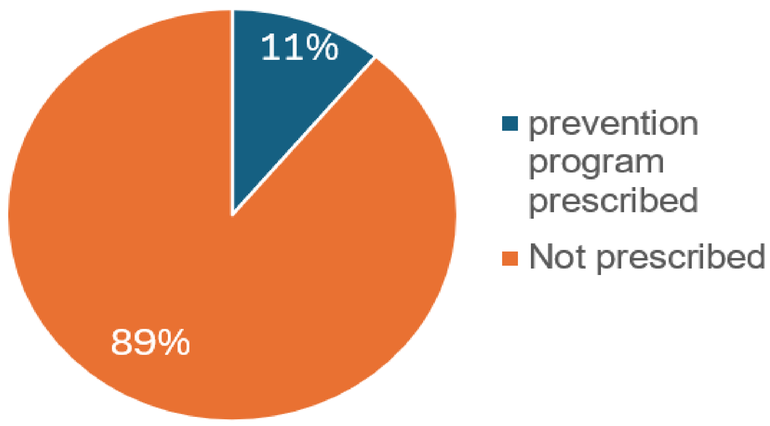



Figure 4 : Prescription of evidence- based injury prevention programmes

## Results

| Lost to follow Up | Not lost to follow up |
|---|---|
| 99 | 176 |
| 36% | 64% |

.Table 1 showing participants lost to follow up – in analysis this was a significant confounding factor.

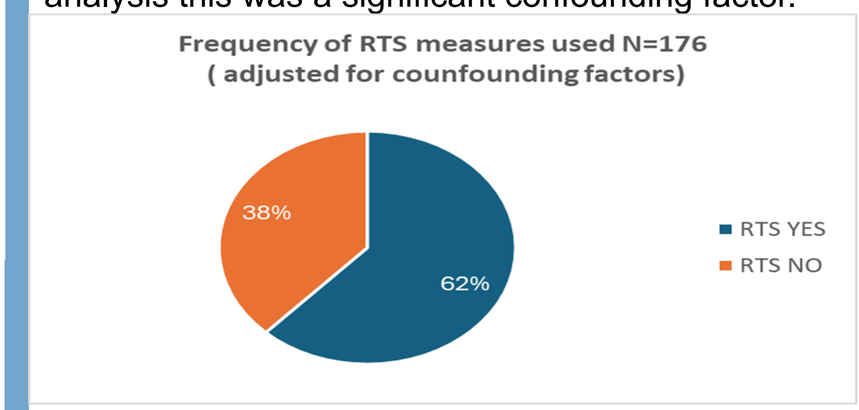



Figure 5 shows the % of patients who had Return to Sport measures completed (Population of N=176 corrected for confounding factor of "Lost to follow up"

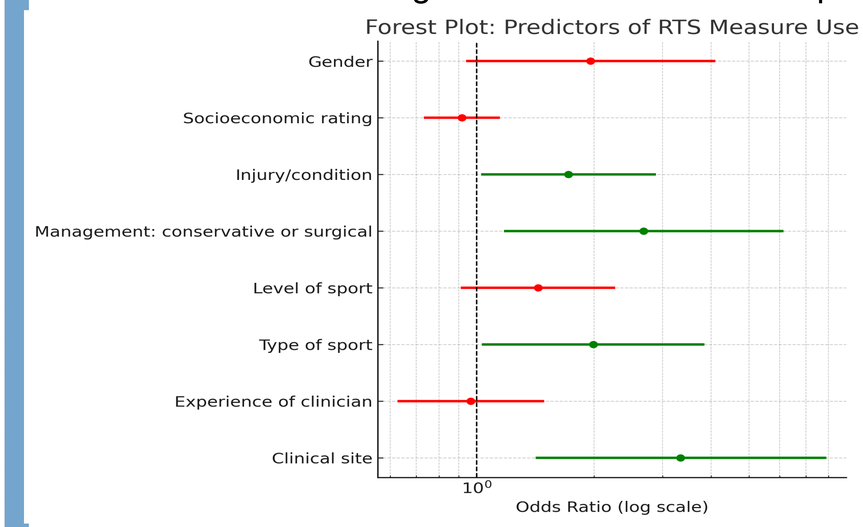



Figure 6 forest plot illustrates the odds ratios (on a log scale) for predictors influencing the use of RTS measures, with confidence intervals indicating the strength and direction of each predictor's association.

## Discussion

This retrospective observational study showed:

Positive influencing factors to RTS being done:

-team sport participant

-knee injury (as opposed to hip or ankle injury)

-surgical candidate

-Rx situated in an outpatient satellite centre as opposed to hospital -based outpatient centre.

•Prior to injury- there was a high level of sport participation by patients over the age of 10 who then had lower limb injury or surgery.

•**Gap 1** : limited use of objective "return to sport " (RTS ) testing during physiotherapy management.

•**Gap 2** : limited prescription of evidence-based sport injury prevention programmes.

## Recommendations

A clear need exists for standardised pathways for RTS assessment, future work will focus on addressing this need with a dedicated service.


**Acknowledgements**: Ethical approval from CHI audit committee. Thanks to academic supervisors- Dr. G O Malley and L.Keating, C. Blake, physiotherapy manager, MSK/ orthopaedic physiotherapy team colleagues & C.Patton and F. Hiney for assistance with data collection.

**Funding** :This project received funding from Royal College of Surgeons RCSI STAr (Strategic academic recruitment) programme.

# Improving information for hip fracture patients and families
# A quality improvement initiative

Midland Regional Hospital Tullamore

## Background:

Every year in Ireland over 4,000 people experience a hip fracture. The impact of a hip fracture can be life-changing, with the right care patients can make a good recovery.

## INTRODUCTION

The aim of this quality improvement project was to improve the quality and consistency of information provided to hip fracture patients and their families in MRHT.

## Objectives:

- Assess patients understanding of hip fracture care
- Identify gaps in information provision patients receive
- Develop and implement a patient information leaflet
- Improve patient preparedness for surgery, rehabilitation and discharge

## Intervention:

Baseline audit of hip fracture patients knowledge using a structured questionnaire

Smart aim to improve patient reported adequacy of information within 12 months

PDSA cycles used to design, test and refine a locally developed patient information leaflet

## RECOMMENDATIONS & CONCLUSION

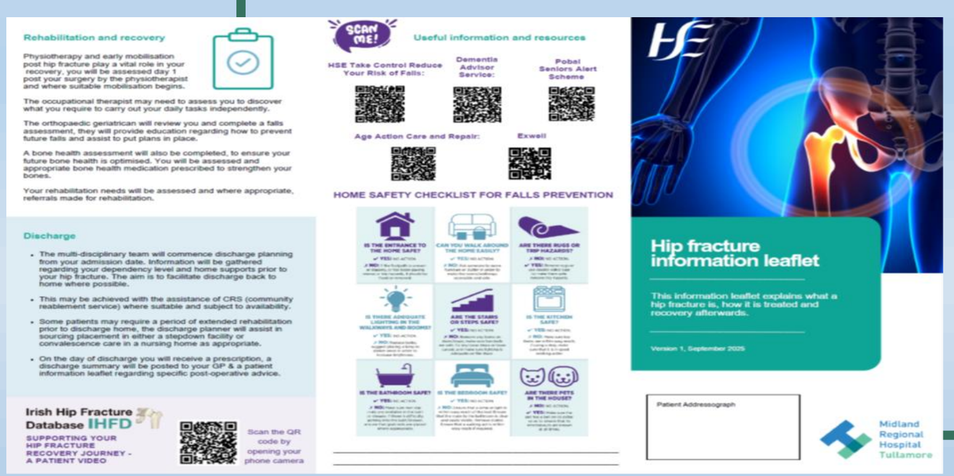
Audit identified significant variation regarding information provided to patients

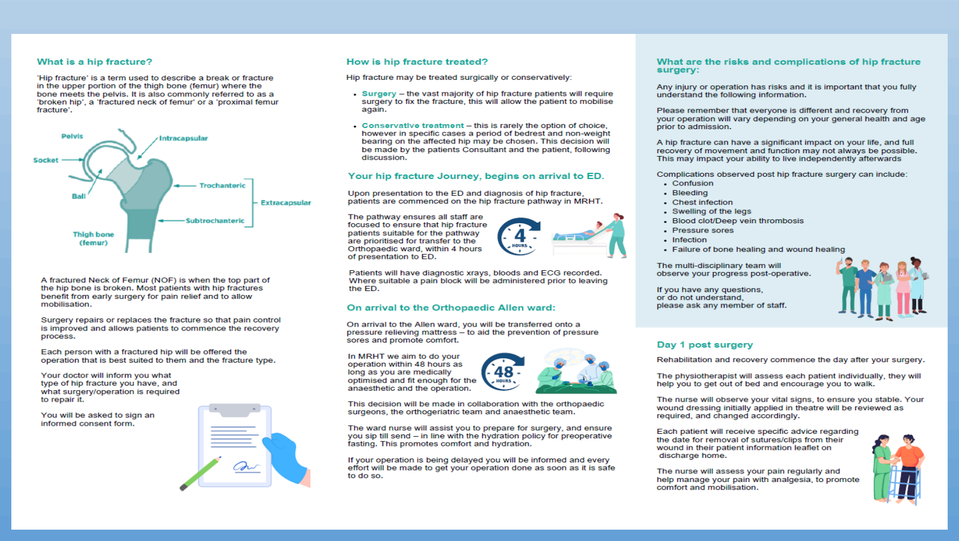
This variation guided the formation of the patient information leaflet

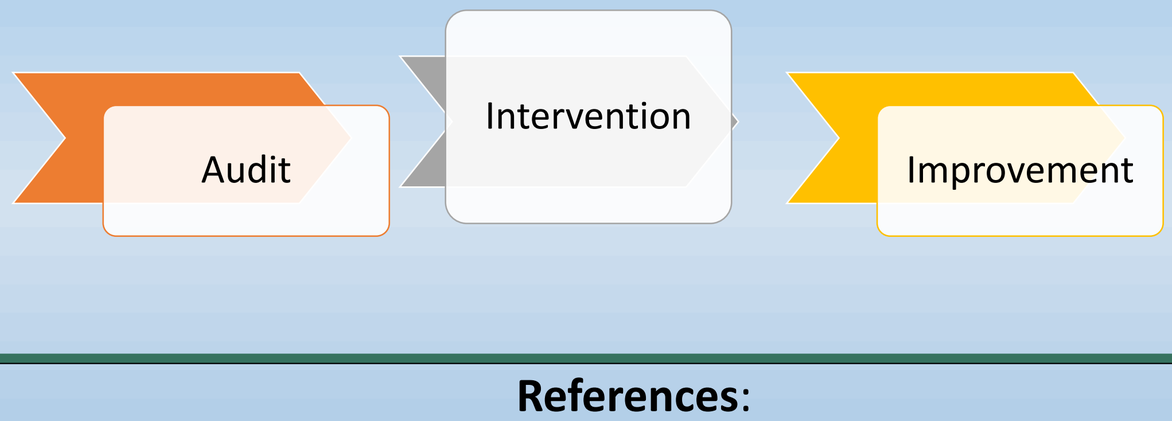
The new information leaflet improved consistency and clarity of information delivery

The new information leaflet provides enhanced patient and family understanding of surgery and recovery. Rehabilitation expectations, falls prevention and community supports.

A structured quality improvement approach enabled the successful development of a patient centred hip fracture information leaflet.




## References:


Ferris, H., Brent, L. and Sorenson, J. (2022a) Cost of hospitalisation for hip fracture – finding from the hip fracture database. *Osteoporosis International*, 33(5), pp. 1057-1065.

National Office of Clinical Audit (2024) Irish Hip Fracture Database National Report 2024. Dublin: National Office of Clinical Audit.

# THE COMPLEXITY CURVE: HOW INPATIENT REHABILITATION NEEDS ARE EVOLVING AT BEAUMONT HOSPITAL 2025

Dr Shelina Seebah, Niamh O'Reilly, Clare Bradley, Claire Smyth, Sarah Burke, Sonya McConnell, Louise McGettigan, Kate Hyland, Méabh Ahern, Alison Coffey, Ivan Clancy, Paul Bernard, Anne Healy, Paula O'Connor, Dr Filipa De Aguiar

Ospidéal Beaumont
Beaumont Hospital

## 1 INTRODUCTION

Rehabilitation is a critical component of acute inpatient care. The increasing age and frailty of the patient population, along with the rise in non-communicable diseases, necessitates early rehabilitation planning and appropriate resource allocation. This audit aimed to assess the complexity of rehabilitation needs among inpatients in Beaumont Hospital using the Rehabilitation Complexity Scale Extended-Acute (RCS E-Acute), a validated tool capturing rehabilitation demand across multiple domains (Turner-Stokes *et al*., 2011).

## 2 OBJECTIVES

This audit aimed to understand the medical, nursing, and therapy requirements of rehabilitation patients through several key objectives: to quantify the number of patients receiving active rehabilitation, categorise patient complexity using the RCS E-Acute tool, and identify those requiring specialist care such as enteral feeding or tracheostomy. It also sought to compare current findings to data from a 2020 audit, guide future staffing, pathway design, and resource allocation, and evaluate the feasibility of routinely implementing the RCS E-Acute in clinical practice.

## 3 METHODS

A one-week point-prevalence audit across all wards in Beaumont Hospital (May 2025) was completed. The RCS E-Acute tool (max score 25) was used to assess complexity across five domains for patients with ongoing rehabilitation needs. Data included age, therapy involvement, special needs and suitability for offsite rehabilitation. A SMART aim guided the audit. Findings were compared with a 2020 audit to inform future quality improvement.

***SMART Audit Aim***

*By May 2025, complete a hospital wide point-prevalence audit using the RCS E-Acute tool to quantify the number of patients receiving active rehabilitation, describe rehabilitation complexity compared to 2020, and identify specialist medical, nursing, and therapy needs*.

*Figure 1. Percentage of patients under and over the age of 65.*

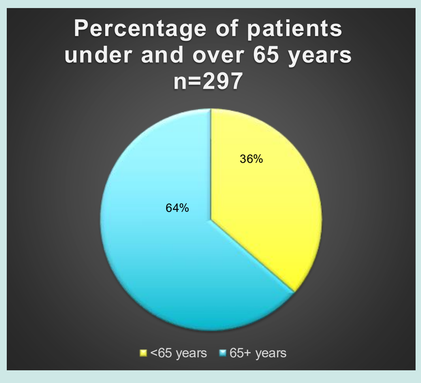
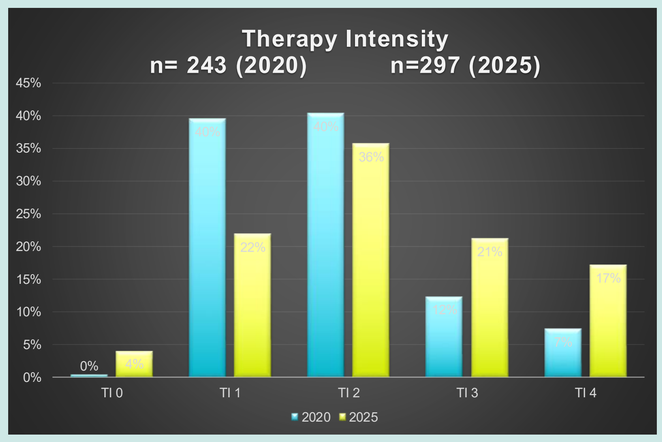
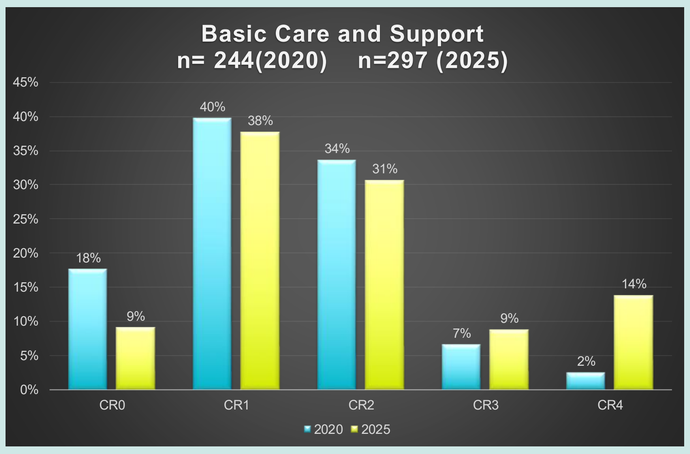



*Figure 2. Therapy Intensity .*



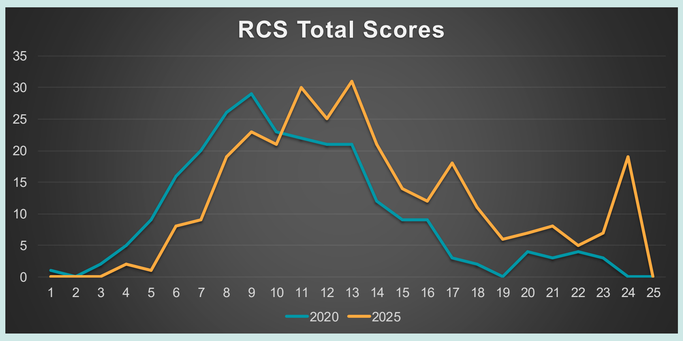

| Score | Therapy Intensity |
|---|---|
| TI 0 | No therapy intervention<br>(or <1 hour per week, rehabilitation needs managed by nursing staff/independent with therapy programme) |
| TI 1 | Low level – less than daily (e.g. assessment / review / maintenance / supervision)<br>Or group therapy only |
| TI 2 | Moderate – daily intervention - individual sessions with one person to treat for most sessions<br>OR very intensive Group programme of ≥6 hours/day |
| TI 3 | High level – Daily intervention with therapist PLUS assistant and/or additional group sessions |
| TI 4 | Very High level – very intensive (e.g. 2 trained therapists to treat, or total 1:1 therapy >30 hrs/week) |

*Figure 3. Basic Care and Support Needs.*




| Score | CARE: Standard rehab needs | Score | RISK: Cognitive behavioural needs |
|---|---|---|---|
| C 0 | Largely independent in basic care activities | R 0 | No Risk |
| C 1 | Requires help from 1 person for most basic care needs | R 1 | Low risk – standard observations only But requires escorting outside the unit |
| C 2 | Requires help from 2 people for most basic care needs | R 2 | Medium risk – above standard observations OR managed under MHA section |
| C 3 | Requires help from ≥3 people for basic care needs | R 3 | High risk – above standard observations AND managed under MHA section |
| C 4 | Requires constant 1:1 supervision – for safety or behavioural management | R 4 | Very high risk Requires constant 1:1 supervision |

*Figure 4 Total RCS-Acute Scores.*




A Total RCSE Acute score of ≥12 indicates a high level of rehabilitation complexity (King's College London, *n d)*

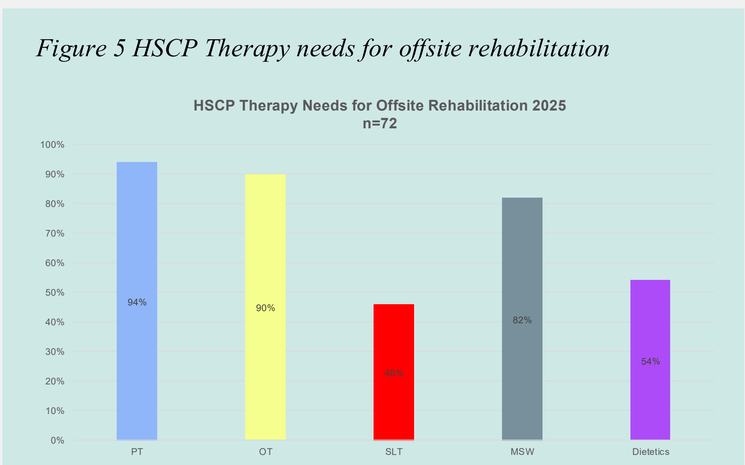
## 4 Results

Out of 732 patients admitted in Beaumont Hospital, 297 were open to HSCP for rehabilitation. Patients under the age of 65 made up 36% of the rehab group (Figure 1). Patients scored higher across all five domains assessed on the RCS E-acute (Figure 2-6). On assessment of medical needs, 62% of patients scored ≥12 on the RCS E-Acute up from 37% in 2020—indicating increased complexity (Figure 7). Therapy intensity and multidisciplinary involvement had also increased. Of the 72 patients considered for offsite rehab, 50% had specialist care needs and 20% required feeding or tracheostomy care.

## 5 RECOMMENDATIONS

- Increase therapy staffing and skill mix
- Enhance nursing and HSCP capacity for high-dependency care (tracheostomy, enteral feeding)
- Integrate RCS E-Acute scoring into daily MDT workflows and digital records
- Align offsite rehab criteria with observed patient profiles and MDT requirements (Figure 4) to reduce delay in discharge
- Reaudit 2026.

*Figure 5 HSCP Therapy needs for offsite rehabilitation*




## 6 CONCLUSIONS

The audit identified clear opportunities to improve patient outcomes, experience, and safety through earlier identification of complexity, improving staffing levels, and increasing offsite rehabilitation capacity for patients with complex needs. Planned changes include embedding RCS E-Acute scoring into routine MDT workflows and digital records and refining referral pathways. Learning will be embedded through staff education and re-audit in 2026 to evaluate the impact on patient care.

## REFERENCE

*King's College London / UK ROC (n.d.) Rehabilitation Complexity Scale Extended (RCS-E) Toolkit v13. Available at: https://www.kcl.ac.uk/cicelysaunders/resources/toolkits/rehabilitation-complexity-scale*

Turner-Stokes, L. *et al*. (2011) 'The Rehabilitation Complexity Scale – extended version: detection of patients with highly complex needs', *Disability and Rehabilitation*, 34(9), pp. 715–720. doi: 10.3109/09638288.2011.615880

# Evaluation of Appropriateness of VTE Prophylaxis in Orthopedic Admissions


**Supervision** Dr syed Nadeem Mujtaba Orthopedic Consultant
**Author** Shoaib Mahboob (CSTEM Trainee)
**Co-Author** Ansar Mehmood (Orthopedic SHO)


**VENOUS THROMBOEMBOLISM (VTE) ; A MAJOR PREVENTABLE CAUSE OF HOSPITAL MORBIDITY AND MORTALITY**

## Aims and Objectives

**'To evaluate whether VTE prophylaxis in orthopedic admissions was prescribed and documented appropriately according to Risk assessment.'**

1. **completion** and **documentation** of VTE risk assessment

2. VTE prophylaxis **prescribed** based on assessed risk

## Methodology

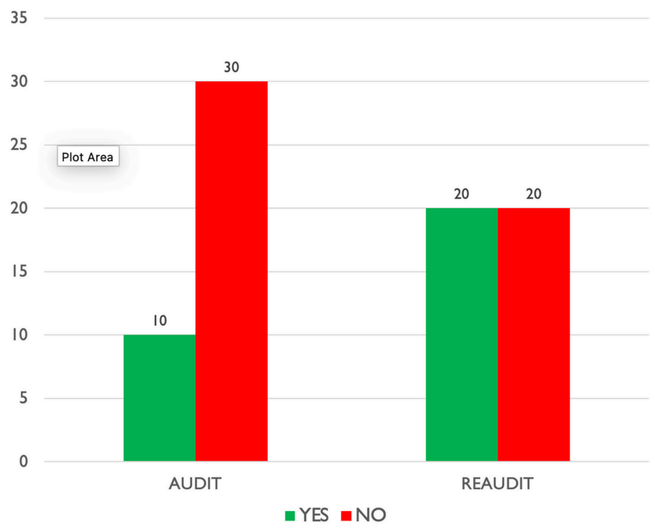
Prospective Convenience

- **Duration**: 4weeks
- **Sample size:** 40 patients
- **Inclusion**: adult orthopedic admission from emergency department
- **Method Used for Improvement**

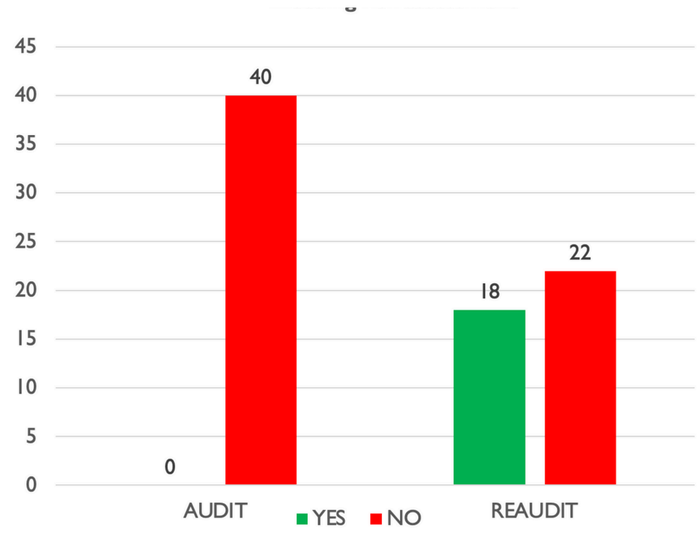
This was a clinical audit conducted against local hospital guidelines. Following baseline data collection, improvement was implemented using PDSA cycles, and a repeat audit was performed to complete the audit cycle.

## Results

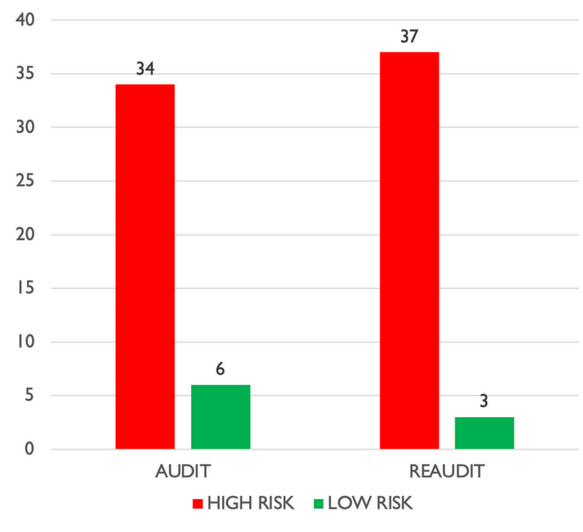
### DVT Risk Assessment Documented



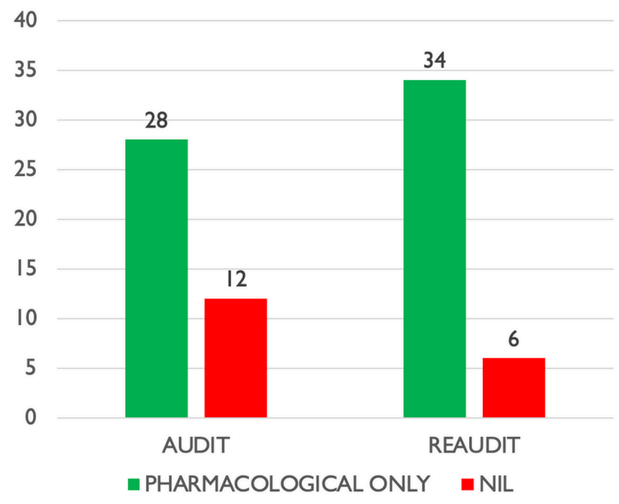

### Bleeding Risk Assessment



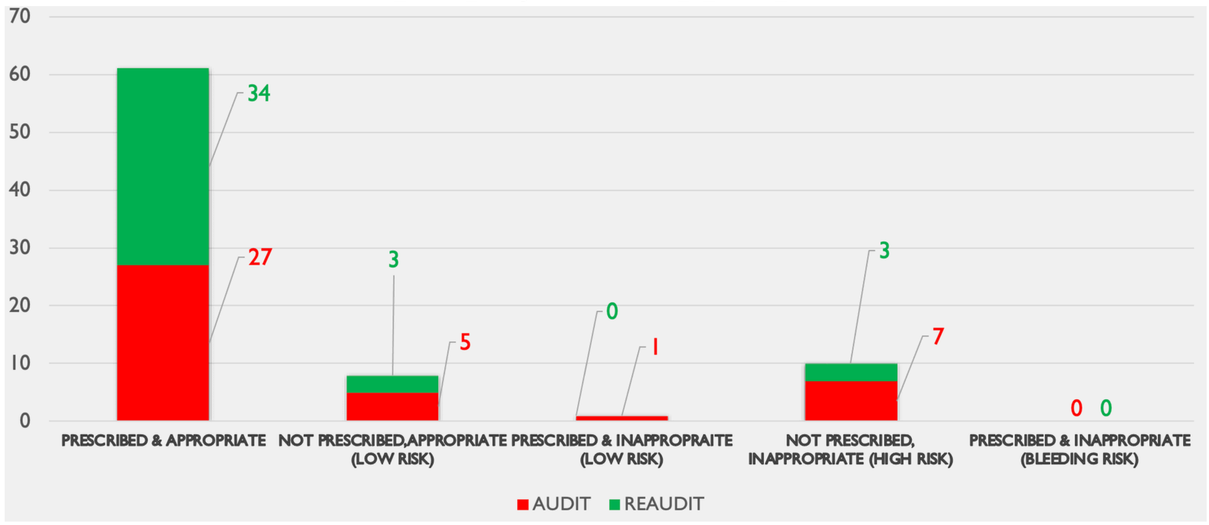

### High Risk/Low Risk




### Type of Prophylaxis




### Thromboprophylaxis Appropriateness




## Conclusion and Next Step

**OVERALL COMPLIANCE 92.5%**

- **ADMISSION PROFORMA IN PROGRESS.**
- Inclusion of VTE risk assessment in admission proforma.
- Continue auditing every 6-12 months to check for compliance

Sláinte Leanaí Éireann

Children's Health Ireland

# Evaluating Inpatient Prescription Documentation Against Current Medication Safety Standards.

Evaluating Inpatient Prescription Documentation Against Current Medication Safety Standards.

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Health Service Executive (HSE) (2018) *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services*. Dublin: HSE.
Medical Council and Pharmaceutical Society of Ireland (2024) *Safe Prescribing and Dispensing of Controlled Drugs*. Dublin.
Health Service Executive (HSE) (2024) *National Incident Management System (NIMS).* Available at: https://www2.healthservice.hse.ie/organisation/qps-incident-management/nims/ (Accessed: 4 February 2026).
State Claims Agency (2023) *About the State Claims Agency.* Available at: https://stateclaims.ie/ (Accessed: 4 February 2026).

## BACKGROUND

Prescribing errors continue to represent a significant risk to patient safety within acute paediatric healthcare settings. Medication errors can result in patient harm, increased length of stay, and reduced confidence in care delivery. At Children's Health Ireland (CHI) Temple Street, Nursing Quality Care Metrics (QCM) are collected monthly across all wards to monitor standards of care and identify areas for improvement. These metrics are aligned with the National Nursing and Midwifery Quality Care Metrics and provide a structured approach to measuring quality and safety in clinical practice.

Audit and review of prescribing practices form a key component of medication safety and quality assurance. Regular prescription audits support the identification of trends, gaps in compliance with prescribing standards, and opportunities for targeted education and system improvement.

## AIM

This audit was undertaken to assess current prescribing practices within the clinical area and to support ongoing quality improvement initiatives aimed at enhancing medication safety and patient outcomes.

## METHODS

A point-prevalence audit of medication charts was conducted across CHI @ Temple Street on 12 November 2025.
A total of 78 inpatient medication charts were reviewed across 12 clinical areas, involving 38 prescribing teams from 14 medical and surgical specialties.

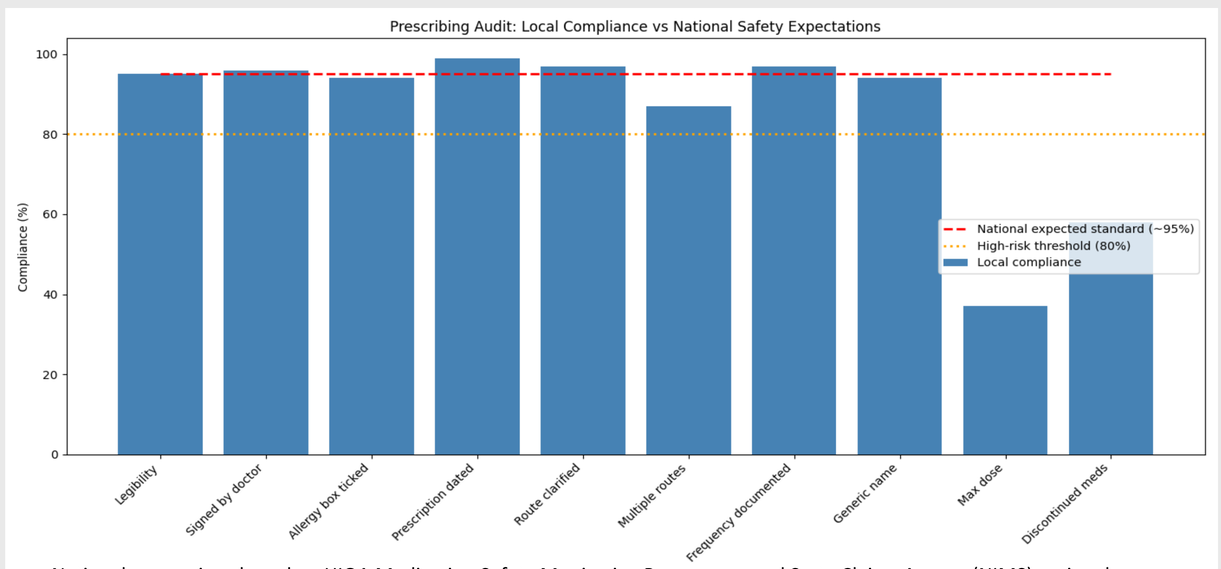

Fig. 1

Charts were assessed against 10 Quality Care Metrics (QCM) prescribing criteria using a standardized audit tool (See Fig 1). Each chart was reviewed once. Charts failing to meet one or more criteria were recorded as containing an error. Data was analysed descriptively to determine compliance with QCM standards.

## RESULTS

Prescribing errors remain prevalent: 80.8% (63/ 78) of medication charts contained one or more prescribing errors.

**Greatest patient safety risks identified:**
Omission of maximum PRN doses · Discontinued medications not signed and dated . Multiple routes prescribed for the same medication.
National incident data show prescribing and administration as the highest-risk stages for medication errors.(State Claims Agency – NIMS; HIQA Medication Safety Monitoring)




National comparison based on HIQA Medication Safety Monitoring Programme and State Claims Agency (NIMS) national medication incident learning reports.

Five prescribing criteria met national safety expectations. Two criteria — maximum dose specification (37%) and documentation of discontinued medicines (58%) — fell well below national safety thresholds and represent priority prescribing risks aligned with national incident trends.

## WHERE DO WE GO FROM HERE


Using a Dissemination and Engagement model demonstrates how multidisciplinary involvement strengthens prescribing practice and prepares staff for Electronic Healthcare Record (EHR) prescribing.
We will continue to monitor our error trends via NIMS and create awareness through the CHI Children's Medication Safety Minutes.
Although EHRs will reduce some errors, good prescribing habits—such as correct doses, choosing the right route, and stopping medicines when needed—must continue to keep patients safe and avoid new risks during the transition.

## ACKNOWLEDGEMENTS

Thank you to all staff and ward areas in Temple Street for their co-operation and dedication to patient safety.
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