Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an Inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	University Hospital Limerick
Centre ID:	OSV-0001064
Address of healthcare service:	St Nessan's Road Dooradoyle Co. Limerick V94 F858
Type of Inspection:	Announced
Date of Inspection:	18/11/2025 and 19/11/2025
Inspection ID:	NS_0173

About the healthcare service

Model of hospital and profile

University Hospital Limerick (UHL) is a model 4* acute teaching hospital operating under the governance of the Regional Health Area - Health Service Executive (HSE) Midwest. The HSE Midwest region is responsible for planning and delivering health and social care services to an estimated population of 413,000 people across Limerick, Claire and north Tipperary. The HSE Midwest health region is structured into two healthcare areas:

- HSE Limerick City and Tipperary North
- HSE Clare and Limerick County.

The Chief Executive Officer for the Midwest Acute and Older People Service (hereinafter referred to as the CEO), leads acute hospital services and older adult care in the region and had overall responsibility and accountability for the operational delivery of healthcare services which included six hospitals, each delivering a range of clinical services and, three rehabilitation and community inpatient services:

- University Hospital Limerick (model 4)
- University Maternity Hospital Limerick
- Nenagh Hospital (model 2†)
- Ennis Hospital (model 2)
- Croom Orthopaedic Hospital (specialist)
- St Ita's Hospital, Newcastle west
- St Camillus Hospital, Limerick
- St Joseph's Community Hospital, Ennis
- St John's Hospital (model 2, acute general public hospital, it is a service provider to the HSE under Section 38 of the Health Act 2004. Services are delivered in line with an agreed annual service level agreement with the HSE and UHL).

To ensure integrated and specialist care across the Midwest Health Region, clinical governance for a range of clinical services provided across the six hospitals was under the governance and leadership of seven directorates. Directorates included:

- cancer services (UHL is a designated cancer centre)
- medicine

* A Model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. These hospitals typically have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, an Emergency Department, including a Clinical Decision Unit on site.

† A Model 2 hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, and a range of diagnostic services.

- peri-operative care
- diagnostics
- maternal and child health
- urgent and emergency care (UEC)
- operational services.

UHL delivers a comprehensive range of services, including:

- acute and medical care
- in-patient services
- major elective surgery
- emergency care
- cancer treatment and care
- high-dependency care
- diagnostic services
- outpatient care.

UHL has developed close links and an official partnership with the University of Limerick (UL) with UL serving as its academic partner.

The following information outlines some additional data on the hospital.

Number of beds	**Inpatient beds (650 total):** ▪ **555** General adult ▪ **49** General paediatric ▪ **28** Intensive Care Unit (ICU) / High Dependency Unit (HDU) ▪ **16** Cardiology / Coronary Care Unit (CCU) / CCU step-down ▪ **2** Paediatric High Dependency Unit (PHDU) **Additional beds:** ▪ **73** Day-case beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

[‡]Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
18/11/2025	*09:05 – 17:45*	Elaine Egan	Geraldine Ryan Angela Moynihan Kay Carlos Úna Cahill
19/11/2025	*08:30 – 15:30*	Elaine Egan	Geraldine Ryan Angela Moynihan Kay Carlos

Information about this inspection
In May 2024, the Minister for Health requested that HIQA conduct a review of urgent and emergency healthcare services in the Midwest Region of Ireland (referred to as the Midwest Review); this was completed in September 2025. As part of that review HIQA undertook an unannounced inspection of the hospital's emergency department January 2025 where compliance against four national standards was assessed: national standard 5.5 (compliant), national standard 6.1 (substantially compliant), national standard 1.6 (non-compliant) and national standard 3.1 (partially compliant). This announced inspection was to: ▪ verify ongoing improvements since the last inspection January 2025 (an inspection undertaken as part of the Midwest Review) ▪ assess the effect of the opening of the new 96 bed block on patient flow in the hospital

- focus on nine national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*.

The inspection focused in particular, on four key areas of known harm:

- infection prevention and control
- medication safety
- the deteriorating patient[**] (including sepsis)[††]
- transitions of care.[‡‡]

The inspection team visited eight clinical areas:

- emergency department including the Clinical Decision Unit
- geriatric emergency medicine unit (GEMU)
- acute medical assessment unit (AMAU)
- acute surgical assessment unit (ASAU)
- 8D (medical/respiratory ward)
- 3C (general medical ward)
- 9F (trauma ward in the new block)
- 8C (isolation ward).

The inspection team spoke with representatives of the hospital's Executive Management Team, Quality and Risk, Human Resources and Clinical Staff.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

What people who use the service told inspectors and what inspectors observed

Patient feedback in emergency department

Inspectors received highly positive feedback from patients about UHL, who highlighted staffs' kindness, attentiveness, and clear communication. Patients described their care as comfortable and praised staff for being helpful and reassuring. Most patients reported being kept informed about their treatment plans

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[**] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

and confirmed that they were offered and received food and drinks and this was observed by inspectors.

Several patients told inspectors they had been admitted promptly following assessment and expressed satisfaction with the overall level of care.

Patients inspectors spoke with acknowledged that staff were busy but still felt well cared for. One patient mentioned a previous positive experience in the emergency department, and several other patients reported that they were brought into the emergency department by ambulance, and felt they were looked after promptly and effectively in the emergency department.

Patient feedback in the clinical areas

Patients reported high levels of satisfaction with the care provided, describing staff as attentive, responsive, and compassionate. Patients who spoke with inspectors stated their treatment plans were clearly explained, patients felt well informed about medications, of test results, call-bells were answered promptly, and food quality was generally praised. Staff were commended for professionalism and kindness despite busy conditions.

Patients also stated that they would speak with a staff nurse if they had a complaint, none of the patients inspectors spoke with reported having any complaints. While most feedback was highly positive, some patients highlighted delays in the emergency department, lack of privacy when on trolleys, and car parking as areas for improvement. This is discussed further under national standard 1.8.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce, and use of resources. University Hospital Limerick was found to be compliant with three national standards (5.2, 5.5 and 5.8) and substantially compliant with one national standard (6.1). Key inspection findings leading to these judgments on compliance are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. Organisational charts detailed the management reporting structures, and the reporting arrangements for governance and oversight committees. The governance arrangements outlined to inspectors were consistent with those detailed in the hospital's organisational charts.

Executive Management Team

The CEO was the senior accountable officer with overall responsibility and accountability for the governance and the quality of health services delivered within this hospital and across all hospitals and older people services in the Midwest Region. A well-established reporting structure was in place from the CEO to the Regional Executive Officer (REO) of the Health Service Executive (HSE) Midwest, and subsequently to the CEO of the HSE.

The EMT was chaired by the CEO, and membership was multidisciplinary. The EMT met monthly in line with its terms of reference. The purpose of the EMT was to support and assist the CEO and provide effective leadership, expertise and direction, to ensure that the organisation delivers on the objectives and key performance requirements as set out in its service plan. The hospital had established seven clinical directorates: urgent and emergency, medicine, peri-operative, child and maternal, cancer, diagnostic and operational services. Inspectors reviewed minutes of meetings and it was evident that all clinical directors were in attendance at the EMT meetings and submitted reports to the EMT. The Chief Director of Nursing and Midwifery (CDOMN) was a member of the EMT, and it was evident there was full oversight of the nursing services provided within the hospital.

Quality and Patient Safety Committee

In August 2025, the Quality and Safety Executive Committee was restructured and renamed the Quality and Patient Safety Committee (QPSC). The QPSC reported to the EMT, and to the CEO. This committee was responsible for providing oversight and ensuring robust governance of the quality and patient safety agenda across all hospitals in the Midwest Health Region. The QPSC meetings were held quarterly, followed a set agenda, and operated under a terms of reference. Meeting minutes reviewed reflected that meetings were chaired by clinical directors on a rotational basis, minutes were reviewed and approved at each meeting, and time-bound actions were assigned to a responsible person. The QPSC received reports from committees of three of the four high-risk areas of focus: the Hospital's Infection

Control Committee Meeting (HICCM), the Medication Safety Committee (MSC), and the Deteriorating Patient Steering Committee (DPSC).

The Discharge Steering Committee (DSC) was co-chaired by the CDOMN and reported to the CEO on a quarterly basis through the Urgent and Emergency Directorate.

The EMT and hospital committees such as the HICCM, the Drugs and Therapeutics Committee (DTC) and, the MSC, the DPSC, and the DSC all met in accordance with their respective terms of reference, with formal agendas in place. Inspectors review of meeting records indicated that minutes from previous meetings were consistently reviewed. While most actions from committee meetings were tracked, not all were time-bound (for example, the DTC, DSC, and the Antimicrobial Stewardship committee). The terms of reference for the HICCM were in draft and scheduled for approval at the next HICCM.

In summary, inspectors found that formal governance arrangements were in place to assure the delivery of high-quality, safe, and reliable healthcare at the hospital. A structured reporting process was established from each governance committee to the QPSC, up to the CEO, the REO, and ultimately to the CEO of the HSE. Based on documentation reviewed and from discussions with relevant staff, inspectors found that each governance committee actively discussed and monitored information on performance, quality of healthcare services, and compliance with defined metrics.

Judgment: Compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Effective management arrangements were in place to support and promote the delivery of high-quality, safe, reliable healthcare services. Hospital management had established several committees to achieve planned objectives and ensure effective management arrangements for infection prevention and control, medication safety, the deteriorating patient and safe transitions of care of patients. Management systems were also established to oversee patient flow from the emergency department through the hospital and into the community.

Infection prevention and control

The hospital's Infection Prevention and Control Team (IPCT) actively supported staff in implementing infection control practices. Led by a consultant microbiologist, the IPCT reported on monitoring and surveillance activities to the HICCM. A number of subcommittees reported into the HICCM: Decontamination, Antimicrobial Stewardship, Estates and Hygiene Steering Committee. The HICCM had developed and approved the hospital's Annual Infection Control Programme for 2025, outlining priorities and the work plan for the year. Inspectors noted that progress on the implementation of this programme was formally reported to the QPSC and the CEO. The Infection Prevention and Control Department Midwest Acute End of Year Report 2024 outlined the hospital's performance in infection control, including surveillance, monitoring, and key performance indicators.

The hospital's AMS programme[§§] plan 2025 was overseen by a consultant microbiologist / consultant in infectious disease, antimicrobial pharmacists and infection prevention and control nurses. The AMS pharmacist reported to the HICCM and the DTC, and oversaw local implementation and monitoring of the AMS programme on a day-to-day basis.

Medication safety

The hospital's pharmacy service[***] was led by the chief pharmacist. The Drugs and Therapeutics Committee (DTC) was the overarching committee overseeing the quality and safety of the pharmacy service and also supported medication safety practices. The DTC was a subcommittee of the QPSC and had defined and formalised reporting to that committee. The hospital's Medication Safety Programme was implemented by three medication safety officers (MSOs). The MSOs reported directly to, and were overseen by, the pharmacist executive manager, and reported to the DTC monthly. Medication safety was discussed under each Directorate at the QPSC meeting held four times a year. Items discussed included medication incidents and staffing deficits in pharmacy department. From the evidence provided during this inspection, it was clear that there was effective oversight and management of medication safety at the hospital.

Deteriorating patient

The hospital had implemented a Deteriorating Patient Improvement Programme[†††] under the leadership of the clinical director. The programme was designed to ensure

[§§] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.
[***] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[†††] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the HSE. Early Warning Systems (EWS) improve recognition and response to signs of patient deterioration. A number of EWS designed to address individual patient needs are in place in acute hospitals.

the timely recognition and management of clinically deteriorating patients. Governance was provided through the Deteriorating Patient Steering Committee (DPSC), with several subcommittees reporting into the DPSC, including:

- the Resuscitation Committee
- the paediatrics sepsis subcommittee
- the emergency department sepsis subcommittee
- subcommittees representing each hospital site within the Midwest health region.

A defined and formal reporting structure was in place, with the DPSC reporting quarterly to the QPSC. A review of meeting minutes confirmed attendance by representatives from all subcommittees. Key agenda items included: audit results for sepsis, the Irish National Early Warning Score[‡‡‡] (INEWS), the Irish Paediatric Early Warning System[§§§] (PEWS), and the Irish Maternity Early Warning System[****] (IMEWS), reviews of recent cardiac arrest cases and updates on staff training. While inspectors noted that the Emergency Medicine Early Warning System[††††] (EMEWS) had not been included as an agenda item at DPSC meetings, it was discussed at the QPSC meetings. A recent quality improvement initiative had introduced digital INEWS in several clinical areas, with plans for hospital-wide implementation. From the evidence provided during this inspection, it was clear that there was effective oversight and management of the deteriorating patient at the hospital.

Transitions of care

Established management arrangements were in place to oversee hospital activity and address factors influencing healthcare service demand, as well as ensuring safe and effective transitions of care. Hospital activity, capacity, patient acuity, and responsiveness to service demand were monitored and managed through a series of structured daily, weekly and bimonthly meetings and, since the most recent inspection undertaken in January 2025, the following new meetings were convened:

- monthly meetings in the emergency department re social inclusion
- new Discharge Steering Committee meeting
- new medical programme board met fortnightly, focused on early discharge and reported to chief operations officer (COO)
- new peri-operative meeting which identified improvements in recovery times and bed allocations

[‡‡‡] INEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in adults.

[§§§] PEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in children
[****] IMEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in pregnant women.
[††††] Emergency Medicine Early Warning System (EMEWS) is recommended for adults patients (16 years and older) attending emergency departments to support the recognition of, and appropriate response to, the deteriorating patient.

- medical hang-back meeting where all clinical teams were updated on bed availability across the Midwest health region
- CNMs from all clinical areas now attended a daily hub meeting in the bed management office which inspectors attended.

Hospital management informed inspectors that the hospital normally was working at 120% capacity in terms of overall bed occupancy. The hospital's emergency department attendance rate in 2024 was 87,195 (an average of 238 daily presentations) and was 62,459 up to August 2025 (an average of 257 daily presentations), which demonstrated an average increase in 19 daily attendances. In the weeks preceding the inspection, the number of patients accommodated on trolleys had decreased following the opening of 96 new beds in October 2025.

On the first day of the inspection, the hospital was in escalation. The emergency department was operating above its planned capacity of 49 treatment bays. There were 6 patients admitted on trolleys in the emergency department corridors and 15 patients admitted on trolleys in 11 clinical areas across the hospital. This was an improvement on the previous HIQA inspection in January 2025 when there were 20 patients in the emergency department admitted and waiting on an inpatient bed and 43 patients were accommodated on trolleys in clinical areas.

It was evident from speaking with management and staff in the emergency department there was a strong emphasis on achieving compliance with the 24-hour Patient Experience Times (PETs) target, alongside ensuring prompt assessment and early access to specialist emergency and geriatric care for patients aged 75 years and older. Bed spaces in CDU, GEMU, AMAU and ASAU accommodated admitted patients. This aligned with the hospital's escalation plan V14. Hospital management had updated the Season Service Level Adjustment Plan 2025/2026 in preparation for a heightened demand for healthcare services and capacity during the winter season. Evidence reviewed during the inspection indicated that there was effective oversight and management transitions of care initiatives, and that these improvements were both sustainable and resilient within the hospital.

In summary, there were effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services, and this was similar to the previous inspection findings from January 2025.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

There were systematic monitoring arrangements in place in the hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital collected a range of different measurements related to the quality and safety of healthcare service provided. This included data relating to compliance against national metrics, hospital activity, patient-safety incidents, audits, complaints, healthcare-associated infections, workforce, training and risks that had the potential to impact on the quality and safety of services. It was evident that collated and performance data was reviewed at meetings of the relevant governance meetings (Quality Patient Safety Committee meetings, EMT and to the Regional Executive Officer).

Risk management

Risk management structures were established in alignment with the HSE's Risk Management Framework policy. The director of the quality risk and patient safety department was responsible for overseeing the effectiveness of the hospital's risk management processes, co-chaired the Quality and Patient Safety Committee and reported to the EMT. Each clinical directorate had a risk advisor and a Serious Incident Management Team (SIMT) who were responsible for ensuring identified risks were managed appropriately and efficiently. The SIMT approved recommendations from patient-safety reviews and recommendations were logged and reviewed by QPSC. The implementation of recommendations and sharing the learning from reviews lay with clinical directorates and this was evident from the clinical areas visited.

Local risk registers complete with mitigating actions documented were observed in the clinical areas visited. Inspectors noted that reported risks were managed by clinical nurse managers (CNMs) with support from the quality and patient safety department. It was evident that risk registers were reviewed regularly and actions to manage and mitigate identified risks were overseen by each clinical directorate and reviewed at the QPSC meetings. High-rated risks from the directorate management team were reviewed by the director of quality risk and patient safety and reviewed at the Executive Performance Management meeting every two months. Patient-safety incidents were managed at clinical directorate level with oversight by the clinical directorates SIMT and reported on to the National Incident Management System (NIMS). In the documentation reviewed by inspectors and from meetings with representatives of the hospital's committees it was evident that patient-safety

incidents were tracked and trended by each clinical directorate's risk advisor and feedback was presented to clinical staff. As per pervious inspection findings, all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. A comprehensive annual overview incident management report was completed each year and submitted to the QPSC and the EMT.

Audit activity

It was evident from documentation reviewed and meetings with management and staff that there were systematic monitoring arrangements in place for overseeing clinical audit activity within the hospital. Each clinical directorate had oversight of all clinical audit activity and ensured the implementation of quality improvements plans arising from audit findings for the clinical services within their area of responsibility. Audit activity and performance in the four areas of focus of this inspection were monitored.

It was evident that audits were completed regularly for example; environmental, hand hygiene, medication safety, INEWS and EMEWS, ISBAR, sepsis and quality care metrics related to patient discharge. Where improvements were identified, time-bound action plans were in place and results disseminated to staff in clinical areas.

The QPS department was responsible for monitoring and responding to findings from the National Inpatient Experience Survey (NIES) 2024. This is discussed further under national standard 1.6.

Overall, the hospital was monitoring and evaluating healthcare services at the hospital to improve care.

Judgment: Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

The hospital's workforce arrangements were managed to ensure the delivery of high-quality, safe and reliable healthcare. Hospital management told inspectors that, since the previous HIQA inspection in January 2025 staffing levels had increased to support the opening of the new 96-bed block in October 2025.

Workforce

Hospital management confirmed that funding had been approved for 264 whole time equivalent (WTE) medical consultant posts across a range of specialties. At the time of inspection, 247 WTE consultants were employed, and recruitment for 17 WTE positions was ongoing. As per previous inspection, a small number of medical consultants employed at the hospital were not on the relevant specialist register with the Irish Medical Council. Hospital management stated that the relevant supports were in place for these consultants and aligned with those recommended by the HSE.

At the time of the inspection, hospital medical consultants were supported by:

- Non-consultant hospital doctors (NCHDs): 572 WTEs of approved 589.45 WTEs were in post (17.45 WTEs vacancies).
- Registrars: 276 WTEs of approved 276.45 WTEs were in post.
- Senior house officer (SHO) grade: 222 WTEs of approved 239 WTEs were in post (17 WTE vacancies).
- Interns: the approved allocation of 74 WTE interns were employed at the hospital.

Hospital management and staff in the clinical areas stated that the current deficit did not impact on patient care and this was evident in the clinical areas visited during inspection. There were three medical registrars covering the hospital at night (two allocated to the emergency department and one to cover the clinical inpatient areas within the hospital).

The emergency department was approved and funded for 15 WTE permanent consultants in emergency medicine. At the time of the inspection, fourteen consultants were permanent, one temporary, and two of the permanent consultants were on approved leave. This represented an increase of 1 WTE consultant in emergency medicine. The hospital was funded for a total of 54 WTE NCHDs in the emergency department which comprised:

- 4 WTE specialist registrars (approved for 5 WTEs)(1 on approved leave)
- 9 WTE NCHDs at registrar level
- 38 WTE SHOs (1 on approved leave)
- 1 WTE intern
- 2 WTE associate emergency physicians.

There was a consultant in emergency medicine on call 24/7 days of the year.

Staffing levels submitted by the hospital to HIQA post inspection indicated that the pharmacy workforce numbers reflected the overall approval of various grades was 58.7 WTEs and the overall actual numbers of various grades was 61.01 WTEs. Pharmacy staff spoke about the challenges in providing a comprehensive clinical pharmacy service and surveillance and promotion of medication safety practices

across the hospital. However, staff in clinical areas visited told inspectors they could access clinical pharmacy when required. This risk along with mitigating actions were recorded on the hospital's risk register and escalated to the REO of the Midwest Health Region.

IPCT comprised two ADONs and 6.6 WTEs at CNM2 grade (approved 10 WTEs) with recruitment of two additional WTEs posts being progressed at the time of inspection.

There was a total of 1698.59 WTE approved nursing posts (inclusive of management and other grades). On the days of inspection 1558.92 WTE of nursing posts were filled and 139.67 WTE nursing posts were vacant (8.22 %). Hospital management told inspectors that agency nursing was used on a daily basis. A recruitment campaign was ongoing and management stated there was a high number of applicants. Additionally, 10 pre-registration nurses commenced employment in the emergency department within the previous two weeks and recruitment was ongoing and being monitored.

Nursing staff were supported by 280.61 WTE healthcare assistants (HCAs). While approved for 352.35 WTEs, 71.74 WTEs HCA posts were vacant. Management said that a rolling recruitment campaign was in place and had initiated a lot of interest. On the days of inspection the clinical areas visited had their full complement of nursing and HCA staff. Inspectors were informed that shortfalls in nursing and HCA staff were managed by redeploying staff from other clinical areas, offering overtime and or by using agency staff. CNMs also told inspectors that rosters were reviewed and adjusted to accommodate service needs. Rosters reviewed by inspectors evidenced minimal deficits. A risk assessment reviewed by inspectors was completed for three HCA deficits in the GEMU and noted there was no impact to patient care on the day of inspection. Hospital management told inspectors that safer staffing phase 2 had been implemented in the adult inpatient services and was being progressed in the emergency department.

The hospital's staff absenteeism rate was tracked, trended and reported monthly to the EMT and HSE. Inspectors were advised that back-to-work interviews were conducted by CNMs at ward level and that exit interviews were completed at time of resignation.

Staff training

As per previous inspection, nursing staff uptake with mandatory and essential training was overseen by CNMs. NCHDs attendance was recorded on the National Employment Record System. Staff confirmed that formal induction training was provided upon commencement of employment. A review of training records by inspectors indicated the following uptake levels:

- medication safety: 100% attendance was achieved in all clinical areas visited
- INEWS: compliance ranged from 89–100%
- IMEWS: uptake ranged from 91–100%
- EMEWS: 93% of nurses and 100% of NCHDs were trained in the emergency department
- sepsis training: compliance ranged from 95–100% across all clinical areas, with 95% of NCHDs trained in the emergency department
- hand hygiene: compliance ranged from 95–100% across all clinical areas, except 3C Ward (88% nurses, 75% HCAs), 9F Ward (75% HCAs) and 8D Ward 80% HCAs)
- standard and transmission-based precautions: uptake ranged from 91–100%, except 8D Ward (82%), and 3C Ward (75%)
- basic life support training was identified by inspectors as an area for improvement across all clinical areas, with the exception of 8D Ward (91%).

In summary, while staffing deficits remain when comparing approved levels to actual staff employed across key healthcare professions, there had been a notable recent increase in staffing levels at the hospital compared to the January 2025 HIQA inspection. Improved staffing levels were observed across number of disciplines of staff including; consultants, NCHDs, registrars, SHOs, and pharmacists. Hospital management continued to actively recruit across disciplines. Training records from the clinical areas visited on the day of inspection showed close to full compliance rates for the mandatory training related to IPC, INEWS, IMEWS, sepsis, hand hygiene, standard and transmission-based precautions and basic life support for the nursing and healthcare assistant staff as relevant. It was evident from interviews with management and staff that continuous education was a focus. However, staff training in basic life support (all areas visited except 8D), hand hygiene (HCAs in wards 3C, 9F and 8D) and standard and transmission-based precautions (except wards 8D and 3C) require additional focus.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. University Hospital Limerick was found to be compliant with two national standards (1.8 and 3.3), substantially compliant with one national standard (3.1) and partially compliant with two national standards (1.6 and 2.7).

Key inspection findings leading to these judgments are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

Patients in the three clinical areas visited 8D, 8C and 9F (9F new block) were generally accommodated in single ensuite rooms which promoted privacy, dignity and confidentiality of patients receiving care. 3C Ward comprised multi-occupancy rooms with privacy curtains around each bed space. Patients had access to individual call-bells, oxygen and suction points at all bed spaces. Healthcare records were securely stored behind the nurses' stations in all clinical areas; however, inspectors noted the absence of privacy covers for end-of-bed notes in 3C Ward. This was this brought to the CNM's attention who stated it would be addressed.

Nine patients were accommodated on trolleys in the AMAU, with privacy curtains around each bed space. All patients had risk assessments completed to assess their suitability for trolley placement, and inspectors observed that patients accommodated on trolleys were independent in meeting their care needs.

Patients in the emergency department were complimentary of the care received and stated staff were "very good", "happy with level of care received" and "staff were very busy", "offered food and fluids regularly" and were kept informed about their plan of care. A number of patients told inspectors they were "waiting on tests or test results".

Noting the limitations of the current design and layout of the emergency department in respect of the volume of attendances managed in the ED, it was evident since the last inspection that considerable efforts had been made by management and staff to promote patient privacy and dignity in the department. Inspectors were advised that a designated cubicle in the emergency department was reserved for patients requiring particular clinical procedures thus ensuring a level of privacy and supporting patient dignity. Portable privacy screens were observed in use, which provided a degree of privacy for patients accommodated on trolleys in the emergency department corridors. Patients accommodated on trolleys in Zone A had access to call-bells and all other patients in zones B and C were in view of staff from the nurses' stations. Inspectors noted that each patient had a risk assessment completed to determine their suitability for trolley placement. Staff stated they

focused on ensuring that older and vulnerable patients with specific care needs such as those receiving oncology or haematology treatment, and end-of-life care were prioritised for a single room and or cared for in a single cubicle in the CDU within the emergency department while waiting on an inpatient bed. The recommended spacing of one-metre between trolleys was not always adhered to in the emergency department corridors. However, inspectors were informed that the trolley placement was aligned with the hospital fire safety plan.

To improve compliance with this national standard a number of measures were implemented in the emergency department following HIQA's previous inspection in January 2025 and included:

- patients accommodated on trolleys in Zone A now had access to both oxygen and a call-bell
- intentional patient experience rounding was implemented. This was observed on inspection
- ongoing collaboration with the Patient Advocacy and Liaison Service to enhance engagement and address patient concerns. This was very evident on the days of inspection
- introduction of new property boxes for patients
- new hygiene boxes containing basic toiletries were introduced for patients attending the hospital who required essential personal care items
- a new dedicated clothing budget had been established. New clothing was provided to those who required it prior to discharge, supporting the promotion of privacy and dignity
- additional shower facilities for patients were installed in the emergency department
- the escalation plan had been reviewed/updated to reflect the practice of admitting patients on trolleys to ward trolley spaces to mitigate overcrowding in the emergency department, with a cap of 10 patients on the emergency department corridors.

Following the National Patient Experience Survey 2024, there had been an increased focus on improving the discharge process and enhancing patient information. Initiatives included incorporating the 'My Medicines' list into a redesigned patient booklet, which was more user-friendly and provided clear explanations of the emergency department's zones and areas. Communication training with staff had also been strengthened through the facilitation of 30-minute engagement sessions in clinical areas. Additionally, the hospital completed an in-house patient experience survey in June 2025, the results of which improved collaboration with the catering team to address feedback and improve meal services and experiences for patients. The pathways for patients to provide feedback or make a complaint were also improved. Hospital management told inspectors that a comprehensive review of all call-bells across the hospital had been recently completed. Inspectors were informed that a new QIP was in progress. This initiative included the introduction of assistive

technology activated by a light touch or pressure from the person's head or cheek that would allow them to activate the call-bell when assistance was required.

Since the previous inspection in January 2025, the number of patients who received care on trolleys in the emergency department and clinical areas had decreased significantly. The addition of new beds in the 96 bed block had a positive impact and reduced the number of patients accommodated on trolleys in the clinical ward areas noted on inspection January 2025. As a result, compliance with this national standard has improved from non-compliant January 2025 inspection to partially compliant at this inspection. However, notwithstanding the positive initiatives introduced by hospital management and staff, accommodating patients on trolleys on corridors in clinical ward areas remained a risk and did not ensure patients' privacy and dignity.

Judgment: Partially Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Inspectors found that there were systems and processes in place in the hospital to respond to complaints and concerns. The director of quality and patient safety was acting as the designated complaints officer, with responsibility for overseeing complaint management and implementing recommendations arising from complaint reviews. This was an interim measure following the retirement of the previous complaints manager. Hospital management advised that recruitment to appoint a replacement was in progress. Each Directorate had designated complaints officers with oversight of the complaints management process for the clinical services within their area of responsibility. The hospital's complaints management policy "Your Service Your Say (YSYS)" set out the processes and timeframes for acknowledging and addressing complaints. Complaints and compliments were formally submitted for inclusion in the HSE's Feedback Learning Casebook four times a year.

Complaints were logged onto a healthcare management system. Hospital management stated that complaints were systematically tracked, analysed, and reviewed every six weeks at the Complaints YSYS Steering Committee meetings. Designated complaints officers from across the acute sites within the HSE Midwest health region were also in attendance. Furthermore, it was evident that complaint data and trends were discussed quarterly at the QPSC meetings. The director of quality and patient safety also reported monthly to the CEO and the EMT. In September 2025 78.5% of complaints were resolved within the 30-day timeframe

achieving compliance with HSE target of 75%. Examples of quality improvements implemented following recent feedback included:

- fortnightly meetings now convened with the urgent and emergency care director of nursing and business manager to discuss and action complaints, improving response times for resolving complaints
- multidisciplinary communication workshops
- new emergency department boards/leaflets providing information on car parking, available refreshments, and mobile phone charging
- a new standard operating procedure for medication management in the emergency department
- the introduction of labelled patient property boxes
- introduction of fundamentals of care audits
- the establishment of a discharge committee.

Information on how to make a complaint was clearly displayed in clinical areas visited through posters, leaflets, and included in the patient information booklet. In addition, YSYS feedback boxes were positioned throughout the hospital to facilitate patient input. Staff in the clinical areas visited had completed complaints management training on HSELanD.

Staff reported that verbal complaints were resolved at the point of contact with a verbal complaints log maintained in clinical areas. CNMs informed inspectors that feedback on complaints was provided to the Directorate, the Director of Nursing, at assistant director of nursing (ADON) meetings and shared with staff during huddles. Patient advocacy liaison officers also supported staff in resolving complaints at the point of contact. Furthermore, information on independent patient advocacy services was available in the clinical areas visited and included in the hospital handbook for patients and visitors. Patients in clinical areas indicated to inspectors that, should they wish to lodge a complaint, their first point of contact would be a staff nurse.

The hospital undertook an internal patient experience survey to assess service quality and patient satisfaction. This survey aligned with the methodology and standards of the HIQA National Patient Experience Survey. Inspectors reviewed the findings of the hospital's Inpatient Experience Survey June 2025 which showed 92% of respondents said they had a good to very good experience which was a significant improvement on 76.3% from 2024.

Overall, inspectors found that systems were in place to respond effectively to complaints and feedback.

Judgment: Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

Inspectors visited a number of clinical areas including the new 96 bed block (9F Ward), the emergency department, the clinical decision unit, the AMAU, the ASAU, wards 3C, 8C and 8D.

Hospital management acknowledged the need for infrastructural upgrades in certain clinical areas. While a refurbishment programme had already commenced, further works were scheduled to be implemented across additional clinical areas in 2026.

The physical environment in the clinical areas inspected was generally secure, clean, and well maintained. In 8C, 8D, and 9F wards, all patients' rooms were single occupancy with ensuite bathroom facilities. Inspectors found that the ensuite areas were clean and well-maintained, with cleaning checklists completed in accordance with hospital policy.

Patient lockers were not available in the ASAU for secure storage of personal belongings particularly for patients who would be there for a number of days.

Infrastructure in 3C Ward and the emergency department showed signs of wear and tear, including chipped paintwork and cluttered corridors. The emergency department comprised multiple zones designed to support triage, resuscitation, and patient assessment, including dedicated areas for adults, paediatrics, and for patients requiring acute mental health support. Facilities included resuscitation bays, isolation rooms, a secure room, and a negative pressure room. High patient volumes resulted in patients being accommodated on trolleys in corridors across zones A, B, C, and the Clinical Decision Unit (CDU). While improvements were recently made, such as providing oxygen, call-bells and dedicated nursing staff for patients on trolleys in the resuscitation corridor, overcrowding and limited space was observed on the days of inspection. Toilets, shower rooms, and ensuite facilities were available in each of the areas; however, facilities were insufficient for the number of patients accommodated in the emergency department, particularly during periods of overcrowding. Inspectors observed that all toilets, shower rooms and ensuites in the emergency department were clean and well maintained, with cleaning check lists completed.

All clinical areas visited had dedicated cleaners, with hospital cleaners available out of hours. CNMs and the cleaning supervisor were responsible for overseeing cleaning standards and ensuring that daily cleaning schedules were implemented within their respective areas. Staff confirmed that there was sufficient cleaning staff in the

clinical areas. Terminal cleaning[‡‡‡‡] was carried out by designated cleaning staff. The hospital employed a combination of in-house cleaning staff and contracted cleaning personnel to deliver environmental hygiene services. Cleaning staff demonstrated good knowledge of environmental and hygiene practices, supporting compliance with infection prevention and control standards.

Inspectors were informed that healthcare assistants (HCAs) and nurses were responsible for cleaning equipment. All clinical areas visited used a green tagging system to indicate that equipment had been cleaned and was ready for use. Inspectors observed that equipment was clean and also noted that clean and used linen were appropriately separated, ensuring compliance with infection control protocols. Hazardous substances were found to be securely stored in designated areas across the clinical areas visited.

Patients requiring standard and transmission-based precautions were generally accommodated in single rooms. Inspectors noted that risk assessments, complete with appropriate control measures were in place in 3C Ward, for patients requiring contact precautions for MRSA[§§§§] and VRE[*****].

In the clinical areas visited, isolation room doors were observed closed in line with best practice. The use of infection prevention and control signage was found to be correct and appropriate in most clinical areas, clearly indicating the required precautions. Personal protective equipment (PPE) was readily available outside single rooms.

Alcohol based hand sanitiser dispensers were strategically positioned throughout the clinical areas, making them easily accessible to staff. Hand hygiene awareness signage was clearly visible, promoting good practice. It was observed the hand hygiene sinks were compliant with national best practice recommendations in all clinical areas with the exception for 3C Ward.

Bed capacity

Current hospital bed capacity as outlined by hospital management was 650 in-patient beds and 73 day case beds, at the time of this inspection.

Hospital management outlined several strategic and operational initiatives aimed at improving bed capacity and infrastructure. Planned measures included:

- the transfer of appropriate surgical care to an off-site surgical hub scheduled to open in 2026
- the construction and commissioning of an additional 96-bed block on-site in 2027
- the opening of a new private hospital in Limerick in the fourth quarter of 2025

- the Acute Hospital/In-Patient Bed Capacity Expansion Plan 2024–2031 identified further capacity increases across the region, including 42 beds for St. John's Hospital, 48 for Ennis Hospital, and 24 for Nenagh Hospital.

However, the contract for utilisation of 50 post-acute rehabilitation beds in Nenagh Transitional Care Unit to support the HSE expired in September 2025. This impacted the overall net gain of the new 96-bed build which resulted in 46 actual bed gain.

Additionally, with regard to patients accommodated on trolleys in clinical ward areas; the addition of new beds in the 96 bed block had a positive impact and reduced the number of patients accommodated on trolleys in the clinical ward areas noted on inspection January 2025. However, the continued placement of patients on trolleys in ward clinical areas is not a sustainable response to delivering safe patient care. Management stated that the opening of the second 96 bed block would further reduce the number of patients on trolleys in ward clinical areas.

In summary, since the last inspection undertaken in January 2025, bed capacity within the hospital had improved through the implementation of strategic and operational initiatives. These measures were aimed to enhance the physical environment and support the delivery of high-quality, safe, reliable care, the status of which will be assessed on the next inspection. However:

- hand hygiene sinks on 3C Ward were not HBN compliant
- patient lockers were not available in the ASAU for secure storage of personal belongings
- toilet and shower facilities were insufficient for the number of patients accommodated in the emergency department, particularly during periods of overcrowding
- infrastructure in 3C Ward and the emergency department showed signs of wear and tear, including chipped paintwork and cluttered corridors.

Judgment: Partially Compliant

‡‡‡‡ Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

§§§§ Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used.

***** Vancomycin Resistant Enterococci (VRE) are bacteria that live in the bowel. VRE can cause an infection if it gets into your bladder, kidneys or blood.

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services

The hospital had arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care.

Risk management

There were systems in place to proactively identify, assess and manage immediate and potential risks to patients. All risks were analysed using the HSE Risk Assessment Tool. Risks, along with associated controls and assigned actions to mitigate these risks to patients, were recorded on local risk registers viewed by inspectors. For example these risks included overcrowding with admitted patients on trolleys, lack of single rooms, and physical/verbal assault. It was clear from meeting minutes and discussions with management and staff that all departmental risk registers were reviewed quarterly by CNMs, risk advisors, and the director of quality risk and patient safety. CNMs stated they were responsible for implementing and overseeing the effectiveness of actions. It was evident that risks that could not be managed in clinical areas were escalated to the relevant clinical directorate SIMT and recorded on the directorates risk register. High-rated risks not managed at clinical directorate level were escalated to the hospital's EMT and recorded on the corporate risk register. These included risks related to infrastructure, staffing levels, overcrowding, the risk of healthcare-associated infection due to overcrowding in the emergency department and, the redeployment of locum consultants. It was evident that the risk register was reviewed and corrective measures were regularly reviewed. Management stated and staff confirmed that risk management training was provided. Risk was not a specific agenda item on all committee and EMT meetings, however, it was evident to inspectors that risk was discussed at each meeting.

Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. Triage waiting time was 11 minutes on day one of inspection, and this was in adherence with a KPI of 20 minutes or less. Inspectors were informed of deployment of additional nursing staff to triage when there was an increase of patient presentations and this was in adherence with the emergency department internal escalation plan. On day one of inspection, inspectors were advised that the hospital was in escalation with 55 patients registered in the emergency department which was above the departments planned capacity of 49 patients (80 were registered in previous inspection), 15 patients were admitted, accommodated on trolleys across 11 clinical areas, and inspectors noted that six patients were accommodated on trolleys in the emergency department corridors (20 in previous inspection). The waiting times ranged from:

- registration to triage times ranged from 3 minutes to 32 minutes. The average wait time was 14 minutes (previous inspection - 15 minutes)

- triage to medical assessment ranged from 14 minutes to 8 hours and 44 minutes. The average wait time was 4 hours and 6 minutes; this was an increase in waiting times from previous inspection findings of 1 hour and 52 minutes
- decision to admit to actual admission to an inpatient bed ranged from 11 minutes to 24 hours and 35 minutes. The average time was 7 hours and 41 minutes; an improvement on previous inspection findings of 13 hours and 35 minutes.

Average PETs compared to HSE Target during HIQA Inspections in 2025

Target/Year	Average % of all patients admitted or discharged within			Average % of patients aged 75 years or over admitted or discharged within	
	6 hours	9 hours	24 hours	9 hours	24 hours
HSE Target	**70%**	**85%**	**97%**	**99%**	**99%**
University Hospital Limerick inspection January 2025	48%	43%	89%	28%	94%
University Hospital Limerick inspection November 2025	34%	55%	97%	52%	94.9%

Data submitted by the hospital and presented in the table above on the emergency department PETs showed improved compliance with the 9-hour and 24-hour targets, particularly for patients aged 75 years and over. However, performance against the 6-hour target had declined, decreasing from 48% at the January 2025 inspection to 34% at this inspection.

The Emergency Medicine Early Warning System (EMEWS) was implemented for non-admitted patients receiving emergency care in the emergency department. At the time of inspection, the EMEWS was completed for all patients triaged as category 2 and category 3 under the Manchester Triage System (MTS) accommodated in Zone A. Hospital management informed inspectors that the EMEWS was currently being rolled out in Zones B and C. Inspectors noted that EMEWS was completed by nursing staff for all patients in Zone A on both days of inspection in line with national guidelines.

Infection prevention and control

In line with national guidelines, patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs) with exception of patients admitted to the GEMU. Inspectors also noted that the MDRO status was not always documented for patients in 8D Ward, and this was brought to the attention of the CNM. There was an electronic alert system to alert staff to patients who were previously inpatients with confirmed MDROs. Management stated that compliance with MDRO screening was audited by the IPCT and this was evident in the annual report 2024 reviewed by inspectors. Inspectors noted that while a small number of patients with confirmed MDROs in 3C Ward were not placed in a single room, risk assessments had been completed. A number of patients admitted in the emergency department, prioritised for isolation rooms were waiting availability of same in the appropriate clinical areas. No outbreak of infection was reported on the days of inspection. Staff confirmed they had access to a microbiologist for advice when required.

Medication safety

While a clinical pharmacy service was not provided in all clinical areas visited, staff confirmed they could contact the pharmacy department if they needed to. It was evident from a sample of records reviewed that pharmacy-led medication reconciliation was undertaken on admission. Medication stock replacement was undertaken by pharmacy staff weekly and the operational ADON had access to stock out of hours. An automated system for medication management system was installed in the emergency department since the previous inspection in January 2025. Staff described how they applied risk reduction strategies with high risk medicines aligned with APINCH[†††††]. There was a list of sound alike look alike drugs (salads) underpinned by a hospital policy. The hospital's medication management policy, prescribing guidelines, including antimicrobial guidelines and medication information were in date, available and accessible to staff at the point of care. Inspectors also observed that medicines were stored securely and in line with national guidance for example, insulin, potassium and opioids. Medication fridge temperatures were monitored in all clinical areas with the exception of 8D Ward and CNM was informed for action.

Deteriorating patient

Staff used the most recent version of the national early warning system for various cohorts of patients. The Irish National Early Warning System ** (INEWS) and the sepsis 6 care bundle were used to support staff to recognise and respond to the

[†††††] A PINCH' medications represented the acronym A PINCH include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

deteriorating patient. The ISBAR$_3$[‡‡‡‡‡] communication tool was used for clinical handovers. The emergency department used the Emergency Medicine Early Warning System (EMEWS), the Paediatric Early Warning System (PEWS) and the Irish Maternity Early Warning System (IMEWS). All staff spoken with were knowledgeable about the INEWS, EMEWS, PEWS and IMEWS escalation and response protocol to ensure timely management of patients with a triggering early warning score. Inspectors conducted a thorough review of a number of patients' healthcare records across all clinical areas visited. It was observed that the majority of INEWS entries were appropriately recorded and adhered to the required frequency. Staff told inspectors that if a patient in the AMAU developed an INEWS of 3 or over, they were transferred back to the emergency department in adherence with the inclusion/ exclusion criteria or moved to an inpatient bed or admitted to a critical care bed if required. Emergency equipment was readily available, such as a resuscitation trolley, an automated external defibrillator (AED), which were checked daily. Oxygen points were at each bedside. Not all patients accommodated on trolleys had access to oxygen; however, a risk assessment was completed to mitigate this risk. Sepsis management guidelines were available to staff.

Transitions of care

There was a system and a policy in place to support discharge and safe transfer of patients within and from the hospital during and outside of core working hours. Each patient had a planned date for discharge. Early consultant rounding and a discharge lounge was used to improve patient flow in the hospital. Inspectors were informed that the critical outreach team supported clinical areas during cardiac arrests, with patients requiring admission to the intensive care unit (ICU), and also with patients following discharge from ICU to the clinical areas. There was a team of patient flow coordinators, and staff used a number of transfer and discharge forms to support the exchange of information on discharge or transfer. No delays were observed with issuing discharge summaries and discharge prescriptions in the healthcare records reviewed by inspectors during the inspection.

A centralised operational bed management system provided information on all beds available in HSE funded hospitals in the HSE Midwest region. The SAFER bundle,** Red to Green System and daily operational meetings supported patient flow and discharge within and from the hospital seven days a week. Patients' average length of stay and delayed transfers of care were reviewed daily with input from clinical teams and community services. Inspectors observed a strong emphasis on admission avoidance, supported by initiatives aimed at reducing hospital length of stay. Key measures included the Frail Elderly Pathway (GEMU and OPTIMEND[§§§§§]) for patients 75 years of age and older, and the establishment of the new Swift Assessment and Treatment (SWAT) team (within the emergency department). Additional supports were provided through the Clinical Decision Unit pathway in the emergency

department, the Acute Medical Assessment Unit (AMAU) pathway, the Acute Surgical Assessment Unit (ASAU) pathway, as well as the Ambulatory Trauma Pathway at Croom Hospital, model 2 site transfers pathway, Community-based services such as Community Intervention Team[******] (CIT), Integrated Care Programme for Older Persons[††††††] (ICPOP) specialist teams, Outpatient Parenteral Antimicrobial Therapy[‡‡‡‡‡‡] (OPAT), and the virtual ward initiatives complemented these efforts. Furthermore, services including Emergency Department in the Home (EDITH), the Limerick Pathfinder programme, and the alternative Pre-Hospital Care Pathway (App), along with several other emergency department pathways (DVT, Stroke, STEMI) contributed to the overall strategy.

At the time of inspection, hospital management reported eleven patients experiencing delayed transfers of care (DTOC). The primary causes identified were delays in securing homecare packages, access to specialist dementia placements, and rehabilitation services which were impacted by geographical constraints. Management also highlighted a strong focus on facilitating weekend discharges, supported by the availability of diagnostic services during weekends. For example, the weekend previous to the inspection 46 patients were discharged and 16 patients were transferred to other healthcare facilities. Delayed discharges and average length of stay (ALOS) were monitored and reviewed weekly. The ALOS for medical patients was 7.7 days (HSE target 7.0) and ALOS for surgical patients was 5 days (HSE target less than or equal to 4.5 days).

The hospital held multiple meetings throughout the day with relevant staff to proactively identify and address issues related to patient flow, bed availability, and operational issues. On the second day of the inspection, inspectors attended an operational huddle where hospital management from all directorates, along with representatives from hospitals within the Midwest health region reviewed key operational priorities. Discussions focused on, for example patients with a length of

[‡‡‡‡‡] ISBAR =**I**dentify, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation), a technique used to facilitate prompt and appropriate communication in relation to patient care and safety is used for clinical handover.

[§§§§§] OPTIMEND HSE refers to the national implementation of the OPTI-MEND (Optimising early assessment and intervention by Health and Social Care Professionals in the Emergency Department).

[******] Community Intervention Team is a nurse–led measure supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.

[††††††] Integrated Care of the Older Persons is delivering integrated care for older people across communities and hospitals in a multifaceted collaborative process between providers, patients and carers. The focus is on patient experience, outcomes and quality care.

[‡‡‡‡‡‡] Outpatient Parenteral Antibiotic Therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.

stay exceeding 20 days (157 patients on that day), potential discharges, scheduled elective admissions, current activity levels, bed capacity, staffing challenges and the availability of diagnostic services such as radiology and laboratory testing.

On the first day of inspection, 15 patients were accommodated on trolleys across 11 clinical ward areas. Of these, four clinical ward areas had two additional patients on trolleys while 7 clinical ward areas had one extra patient admitted on a trolley. Hospital management stated that there were ongoing plans to extend bed numbers in the hospital which is discussed under national standard 2.7.

Policies, Procedures, Protocols and Guidelines

Staff had access to a range of up-to-date, infection prevention control guidance medication safety, transitions of care and the deteriorating patient policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff via a document management system.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm – infection prevention and control, medication safety, the deteriorating patient and transitions of care.

In relation to the emergency department, on the days of inspection, registration-to-triage and admission times showed improvement from the previous inspection. However, the average time from triage to medical assessment had decreased. This requires focus.

Patient experience times in the emergency department had improved since previous inspection in the 9-hour and 24-hour targets, and particularly for patients aged 75 years and over. However, performance against the 6-hour target had decreased and this requires focus.

Judgment: Substantially Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. The process was supported by a policy Local Incident Management Procedure which aligned with the HSE Incident Management Framework 2020. All patient-safety incidents were reported on a local electronic system and the National Incident Management System (NIMS). Staff who spoke with inspectors were knowledgeable about how to report patient-safety incidents. At the time of the inspection, there were a number of serious reportable events

and comprehensive reviews of adverse incidents in progress. This was also evident in the Incident and Risk Management Midwest Acute Hospital Services annual report 2024 which also included associated data on patient-safety incidents. This report was formally submitted to both the EMT, CEO and to the REO.

It was evident that the quality and patient safety team systematically tracked and analysed reported incidents, identifying trends and sharing findings with the relevant Directorates. The most frequently reported patient-safety incidents reported in September 2025 included for example, medication-related events, issues in clinical care and, surgery-related incidents. Inspectors were informed that tracking and trending of patient-safety incidents were shared with CNMs in the clinical areas by quality and patient safety department and the CNMs disseminated this information to staff at CNM meetings and safety huddles. This was confirmed by staff in the clinical areas visited.

Inspectors were told that all relevant infection prevention and control incidents with the associated corrective actions were reviewed. This was also evident in the Infection Prevention and Control Department Midwest Acute end of year report 2024 and in the Quality Risk and Patient Safety September Report 2025.

Medication-related patient-safety incidents were categorised according to the severity of outcome in line with the National Coordinating Council for Medication Error Reporting and Prevention[§§§§§§] (MERP) and were also logged on NIMS. From documentation reviewed and from meetings held with management it was evident that all medication incidents were reviewed monthly at the MSC and quarterly at the DTC and the QPSC meetings.

Management stated and meeting minutes reviewed indicated that incidents related to the deteriorating patient were trended and discussed at the Deteriorating Patient Steering Committee meeting and at the QPSC meetings quarterly. This was evident in the Quality Risk and Patient Safety September Report 2025. Inspectors were informed that all delays in escalating an INEWS had a preliminary assessment completed and were consequently referred to the Serious Incident Management Team (SIMT) for review and appropriate action.

Patient-safety incidents related to transitions of care were reported, and these incidents and associated risks were reviewed by the relevant directorate.

[§§§§§§] The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body composed of 27 national organizations. In 1995, the United States Pharmacopeial Convention (USP) spearheaded the formation of the National Coordinating Council for Medication Error Reporting and Prevention: Leading national health care organizations are meeting, collaborating, and cooperating to address the interdisciplinary causes of errors and to promote the safe use of medications.

The Senior Incident Management Teams (SIMT) role within each directorate was to oversee the management of category 1 and category 2 incidents from notification of incident to completion of the review. The SIMT was chaired by the CEO. It was evident that all preliminary assessment reports (PARs) and internal reviews in progress were discussed at the relevant governance committee, clinical directorate and monitored by the quality and patient safety department and SIMT. A SIMT log was maintained by each clinical directorate to track and monitor each incident on the log.

Hospital management informed inspectors that all recommendations arising from reviews were formally approved at the individual clinical directorate level and subsequently discussed at Quality and Patient Safety Committee meetings. In addition, the recommendations log was regularly reviewed at these meetings to monitor progress, ensure accountability, and track implementation status. Hospital management reported that it was challenging to complete comprehensive reviews of adverse incidents within the national target of 125 days. The complexity of the case and or availability of subject matter experts were the main reasons mentioned by hospital management for the non-compliance with this timeline. Inspectors were told that the appointed patient liaison officer supported patients and kept them updated and informed during the review process. Arrangements were in place to report mandatory notifiable incidents in line with the Patient Safety Act 2023.

Risk and incident management training was integrated into staff induction and supplemented by additional sessions, and face-to-face training as evident in the Incident and Risk Management Midwest Acute Hospital Services report 2024.

Overall, the hospital had a system in place to identify, manage, respond to and report patient-safety incidents using an agreed taxonomy in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

Conclusion

An announced inspection of University Hospital Limerick was carried out to assess compliance with the *National Standards for Safer Better Healthcare*. Overall, the hospital was found to be compliant in five national standards (5.2, 5.5, 5.8, 1.8 and 3.3), substantially compliant in two national standards (6.1 and 3.1) and partially compliant in two national standards (1.6 and 2.7). HIQA last undertook an unannounced inspection of the hospital's emergency department January 2025 when compliance against four national standards was assessed: national standard 5.5

(compliant), national standard 6.1 (substantially compliant), national standard 1.6 (non-compliant) and national standard 3.1 (partially compliant).

Capacity and capability

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe, reliable healthcare services. Notwithstanding the clear benefits delivered by the new 96-bed block significant capacity pressures continue. This was demonstrated by the hospital's ongoing escalation status, continued dependence on surge capacity, admitted patients waiting in the emergency department for an inpatient bed and the persistent use of trolleys for patients admitted to inpatient areas. This was also identified in the Midwest Review undertaken by HIQA and published in September 2025.

There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The workforce arrangements were managed to ensure the delivery of high-quality, safe and reliable healthcare.

Quality and safety

Inspectors found that there were processes in place to respond to complaints and concerns. The physical environment in the clinical areas visited generally supported the delivery of high-quality, safe, reliable care notwithstanding the ongoing capacity deficits. While the design and layout of the emergency department continued to challenge, notable improvements to promote patients' privacy and dignity were observed. Inspectors found that there were systems in place to monitor, evaluate and continuously improve the healthcare services and care provided. The hospital had arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care. There were processes and systems in place to identify, report, manage and respond to patient-safety incidents. However, overcrowding in the emergency department with the high demand for inpatient beds and capacity remain an issue at the hospital. The continued placement of patients on trolleys in ward clinical areas is not a sustainable response to delivering safe patient care. Patients who spoke with inspectors conveyed positive experiences of care and expressed appreciation for the professionalism and dedication of both staff and the management team in the hospital.

Overall, ongoing improvements since the previous inspection were evident. It was clear that the addition of extra capacity has helped support patient flow noting that the Midwest Report stated that additional capacity would be needed in the short

term to further support improvements. HIQA recognises the commitment of the Minister to address this in conjunction with the HSE.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for: University Hospital Limerick

Inspection ID: NS_0173

Date of inspection: 18 and 19 November 2025

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially Compliant

The physical environment did not always ensure that patients' privacy and dignity were protected and promoted in the emergency department.

- Inspectors noted the absence of privacy covers for end-of-bed notes in 3C Ward.

Update Privacy covers are now in use. **Completed**

- The physical environment did not always ensure that patients' privacy and dignity were protected and promoted in the emergency department.

Update:

- Trolley placement is aligned with the hospital fire safety plan.
- Privacy screens are in use
- Protected cubicle for personal care of patients in use.
- Escalation plan in place (v14.)
- Cap set of 20 patients max on corridor trolleys within ED.
- To minimise the number of patients on trolleys in ED, patients are stepped down directly from ED to Model 2 sites, moved to the wards on trolleys and elderly patient moved to the GEMs unit.

Acute pathways are in place that enable the streaming of patients from the ED. • Acute Medical Assessment unit pathway • Acute Surgical Assessment unit pathway • GEMS unit for >75yr old pathway • STEMI pathway • Model 2 site transfers pathway • Clinical Decision Unit pathway • Stroke • Neck of Femur • Virtual ward capacity is currently set at 30, working on increasing capacity to 40. Refer to standard 2.7 for infrastructural updates
Timescale:

National Standard	Judgment
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
• An interim measure following the retirement of the previous complaints manager. Hospital management advised that recruitment to appoint a replacement was in progress. **Update:** Complaint manager in post. **Completed**	
Timescale:	

National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
High patient volumes resulted in patients being accommodated on trolleys in corridors across zones A, B, C, and the Clinical Decision Unit (CDU). The continued placement of patients on trolleys in ward clinical areas is not a sustainable response to delivering safe patient care. It was observed the hand hygiene sinks were compliant with national best practice recommendations in all clinical areas with the exception for 3C Ward.	

Patient lockers were not available in the ASAU Toilets, shower rooms, and ensuite facilities were available in each of the areas; however, facilities were insufficient for the number of patients accommodated in the emergency department, particularly during periods of overcrowding	

- Hand hygiene sinks on 3C Ward were not HBN compliant:

Update: Sink replacement plan in place. **Date for completion: Q3 2026**

- Patient lockers were not available in the ASAU for secure storage of personal belongings particularly for patients who would be there for a number of days.

Update: Plan in place for installing lockers. **Date for completion: End of March 2026**

- Infrastructure in 3C Ward and the emergency department showed signs of wear and tear, including chipped paintwork and cluttered corridors.

Update: Rolling maintenance programme in place for the UHL site. ED & 3c will be prioritised. **Date for completion: End of 2026**

- Infrastructure in Ward 4c

Update: Room 1 & 6 have been were completely refurbished.

- Infrastructure in Ward 1D

Update: Rm 6,5,3,2 have been completely renovated. Main ward toilet has been completely refurbished.

- Infrastructure in Ward 1C (Old trauma ward)

Update: Rm 1,2,3,4,7 have been completely renovated and main ward repainted.

- Toilets, shower rooms, and ensuite facilities were available in each of the areas; however, facilities were insufficient for the number of patients accommodated in the emergency department, particularly during periods of overcrowding.

Update: Additional toilet installed in the resus corridor & in Zone A in October2025

Toilet and shower installed in Zone C in November2025

Update

Long-term

- To complete the construction of a surgical Hub. **Date for Completion Q1 2027**

Update: Modular build to be completed by end of 2026

- To expand the number of transitional beds x100 (level 2&3 rehab beds)

Update: Finalising tender process. **Date for Completion Q3 2026**

- To construct a further 96 bed block **Date for Completion 2028**

Update: Building works have commenced.

- An additional 16 bed modular build to be progressed in 2026

Update: Building works have commenced. **Date for Completion Q 1. 2027**

- To expand the bed capacity on the Ennis site by 48 beds each. The expansion will include new Theatres, SSD and an Endoscopy unit.

Update: Capital submission made

- To expand the bed capacity on the Nenagh Hospital site by 24 beds. The expansion will see the construction of 2 new 24 bedded units, with the movement of the patients from the old infrastructure in Medical 1 to one of the new units.

Update: Capital submission made.

- To extend the UHL campus on another site adjacent to or close to UHL: recommendation from the Health Information and Quality Authority (HIQA) aimed at addressing long waiting times at the hospital in Dooradoyle.

Update: A shortlist of sites has been drawn up and a recommendation for a particular site

- To install a PET scanner on the UHL site

Update: Pet Scan opening Q2 2029

- To repurpose vacated administrative offices in Cancer Services.

Update: Vacated administrative offices converted to clinical space in the Haem/Oncology Day Unit. **Completed**

Timescale:

National Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Performance against the 6-hour target had declined, decreasing from 48% at the January 2025 inspection to 34% at this inspection.	

15 patients were admitted, accommodated on trolleys across 11 clinical areas, and inspectors noted that six patients were accommodated on trolleys in the emergency department corridors (20 in previous inspection).	

Short-term

- To streamline ED processes

Update: Review is currently underway with final plan to be developed by Head of service **Date for Completion:** Q 2 2026

- To appoint a Head of service for ED

Update: Head of service appointed and in place. **Completed.**

- Monitoring of performance

Update: Performance is monitored on a monthly basis, at the Executive management team meeting. **Completed.**

Long-term

- To secure an additional urgent care centre in Limerick city.

Update: Currently looking at a location in the city centre to provide an alternative option for members of the public to reduce the number of presentations to ED.

Timescale:

National Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Compliant

- The terms of reference for the HICCM, which were in draft have been reviewed and signed off. **Completed**
- Chairs of the following committees have been written to ensure that for future meetings that actions are time bound. DTC, DSC, and the Antimicrobial Stewardship committee). **Completed**

Timescale: Completed

National Standard	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
There were 6 patients admitted on trolleys in the emergency department corridors and 15 patients admitted on trolleys in 11 clinical areas across the hospital.	

Update:

- Escalation plan (v14) has been further reviewed/ updated to reflect the additional bed capacity on the UHL site and the current practice of flowing patients on trolleys to ward trolley spaces from ED to mitigate overcrowding in ED with a cap of 20 patients on trolleys on corridors set. **Completed**
- There is ongoing recruitment of staff to maintain the staffing levels across all grades of staff within the Hospital to ensure that patients, awaiting a bed have their care needs met. **Completed**
- Executive management team are located on the UHL site **Completed**.
- Operational site meeting at 9.45 am Monday – Friday with Exec on call convening the meeting at the weekend. This meeting reviews previous days performance, real time data and agrees corrective measures and plan for the day. **Completed**
- KPI of no patient > 75years of age awaiting admission at 8am in the morning in place. Monitored daily by Executive. **Completed/ongoing**
- Integrated DTOC meeting established, which meet weekly to ensure delayed transfers of care are minimised. **Completed**
- Additional bed capacity opened on the UHL Site in 2025
  - 16 beds opened in May on ward 12B
  - 96 bed block opened the beginning of October
  - Secured 10 beds (2026) in Bon Secours hospital to accommodate model 2 criteria patients
- Reduction in bed capacity
  - Bartra beds (50 in total) closed in Nenagh in November 2025
- Several acute pathways are in place that enable the streaming of patients from the ED
  - Acute Medical Assessment unit pathway
  - Acute Surgical Assessment unit pathway
  - GEMS unit for >75yr old pathway
  - STEMI pathway
  - Model 2 site transfers pathway
  - Clinical Decision Unit pathway
  - Stroke
  - Neck of Femur

- Virtual ward capacity is currently set at 30, working on increasing capacity to 40.

Resources:

- There has been an increase to 247 WTE consultants employed.

Update: Additional consultants were recruited in 2025 across a number of specialties, with 241 consultants in post and a further 34 currently in clearance.

- Registrars: 276 WTEs were in post.

Update: The number of registrars has increased to 333 (Includes SpRs).

- Senior house officer (SHO) grade: 222 were in post.

Update: The number of SHO's has increased to 271

- Additional nursing resources recruited in 2025

Update: 262 nursing and HCA posts recruited to support increase of 128 new beds on the UHL campus.
16 new service development ANPs were recruited in 2025.
Safer staffing phase 2 for ED implemented and on review a further uplift of 20 WTE in nursing and 5 HCAs to further support ED underway.

Safer staffing phase 1 implemented with baseline achieved. Uplift of 12 WTE with start dates for all 12 staff. **Date for completion: Q1 2026**

- A risk assessment reviewed by inspectors was completed for three HCA deficits in the GEMU.

Update: Posts have been filled. **Completed**

- pharmacy workforce numbers reflected the overall approval of various grades was 58.7 WTEs and the overall actual numbers of various grades was 61.01 WTEs. Pharmacy staff spoke about the challenges in providing a comprehensive clinical pharmacy service and surveillance and promotion of medication safety practices across the hospital.

Update: Regional pharmacy strategy to be progressed in 2026.

Long-term

- To complete the construction of a surgical Hub. **Date for Completion Q1 2027**

Update: Modular build to be completed by end of 2026

- To expand the number of transitional beds x100 (level 2&3 rehab beds)

Update: Finalising tender process. **Date for Completion Q3 2026**

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- To extend the UHL campus on another site adjacent to or close to UHL: recommendation from the Health Information and Quality Authority (HIQA) aimed at addressing long waiting times at the hospital in Dooradoyle.

Update: A shortlist of sites has been drawn up and a recommendation for a particular site

- To install a PET scanner on the UHL site

Update: Pet Scan opening Q2 2029

- To repurpose vacated administrative offices in Cancer Services.

Update: Vacated administrative offices converted to clinical space in the Haem/Oncology Day Unit. **Completed**

Timescale:

National Standard	Judgment
Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Substantially Compliant

- The terms of reference for the HICCM, were in draft

Update: The terms of reference for the HICCM, have been reviewed and signed off. **Completed**

- Most actions from committee meetings were tracked, not all were time-bound (for example, the DTC, DSC, and the Antimicrobial Stewardship

Update: Chairs of the following committees have been written to ensure that for future meetings that actions are time bound:

-The Drugs and Therapeutics Committee (DTC)

-The Discharge Steering Committee (DSC), and

- the Antimicrobial Stewardship committee). **Completed**

- **Hand Hygiene**: compliance ranged from 3C Ward (88% nurses, 75% HCAs), 9F Ward (75% HCAs) and 8D Ward 80% HCAs)

Update: In recent audits (13.01.2026) Ward 9F achieved 93% and Ward 8D achieved 100% compliance and Ward 3C 93% **Completed**

- **Other training:**

The hospital delivered a focused training programme throughout the year, with particular emphasis on sepsis recognition and management, alongside informed consent, open disclosure, and safeguarding. Sepsis training remained a priority area, supported by regular audits and any non-compliances being subject to review under the incident management framework. Attendance and compliance across all topics were monitored monthly at executive level.

- **Basic life support training** was identified by inspectors as an area for improvement across all clinical areas, with the exception of 8D Ward (91%).

Update: Rolling out additional BLS courses. **Date for completion:** June end 2026

Timescale: