Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of compliance with the *National Standards for Safer Better Healthcare* in **the Mid West Region of Ireland in accordance with Section 8(1)(c) of the Health Act 2007, as amended, with consideration of other health services with the potential to impact urgent and emergency care in the Mid West.**

Work stream 5 of the review of urgent and emergency healthcare services in the Health Service Executive Mid West health region.

Publication date: 30 September 2025

Introduction

University Hospital Limerick is a Model 4 hospital that was managed by the University of Limerick Hospitals Group (ULHG) on behalf of the Health Service Executive (HSE) until early 2024. The HSE then implemented an integrated approach to healthcare service delivery on a phased basis. This resulted in the realignment and integration of the Hospital Group and Community Health Organisation (CHO) structures, with the delivery of acute and non-acute healthcare services organised into six health regions. The six hospitals that comprised ULHG — University Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital, St John's Hospital, University Maternity Hospital Limerick and CHO structures were realigned to the HSE Mid West health region. The HSE Mid West is divided into two healthcare areas — HSE Limerick City and Tipperary North; HSE Clare and Limerick City. HSE Mid West plans and delivers health and social care services for a population of over 400,000 people residing in Limerick, Clare and North Tipperary.

University Hospital Limerick is supported to deliver healthcare by two Model 2 hospitals (Nenagh Hospital and Ennis Hospital), a specialised Model 2 hospital (Croom Orthopaedic Hospital) under HSE governance and an acute, voluntary hospital (St John's Hospital) that provides healthcare services under Section 38 of the Health Act 2004. A range of clinical services are provided across the six hospitals in HSE Mid West, under the governance and leadership of six clinical directorates — cancer service, medicine, peri-operative, diagnostics, maternal and child health directorates, and urgent and emergency care (UEC) directorate. These clinical services include:

- emergency care
- major elective surgery
- high-dependency care
- a range of other medical inpatient services, diagnostic and therapy services
- cancer treatment and care
- outpatient care.

Medical assessment units (MAUs) and injury units are located in Nenagh Hospital, Ennis Hospital and St John's Hospital.

Between March 2022 and November 2023, the Health Information and Quality Authority (HIQA) carried out three inspections of the emergency department in University Hospital Limerick monitoring compliance with the *National Standards for Safer Better Healthcare* (version 2, 2024), hereafter referred to in this document as the 'national standards'. After each inspection, hospital management developed a compliance plan comprising actions to be implemented to bring the hospital into compliance with the four national standards monitored.

Since March 2022, a number of external interventions, including HSE external teams, supported the progress of operational, process and clinical efficiencies at the hospital. Over the three-year period (2022 to 2023), HIQA found some improvements in the level of compliance with two of the four national standards (NS 6.1 and 3.1) monitored during the inspections of the emergency department, but more improvement was needed to bring the hospital into compliance with the national standards 5.5 and 1.6 (see Appendix 1).

The prevailing issue of overcrowding at the hospital is well-documented and in May 2024, the Minister for Health requested that HIQA conduct a review of urgent and emergency healthcare services in the Mid West Region of Ireland (referred to as the Mid West review). The Mid West review will provide advice to the Minister for Health to inform decision-making about the design and delivery of urgent and emergency healthcare services in the Mid West Region of Ireland. The review's terms of reference (TOR) were published in August 2024.

As per TOR 5 of the Mid West review, this report considers compliance with four national standards. These findings will be compared to previous inspection findings and identify areas of progress in working to meet the requirements of the national standards. More generally, the report aims to;

- evaluate the potential impact and benefits of the process improvement and operational effectiveness initiatives on available capacity across other acute, specialist and community services in the HSE Mid West Region
- consider the findings and recommendations of the Report of the Independent Investigation at University Hospital Limerick by Chief Justice Frank Clarke as they relate to operational and safety processes at University Hospital Limerick
- consider other areas of step-down care, which impacts urgent and emergency care capacity in the Mid West Region.

The report is divided into two sections.

Section A: Report of the inspection against the *National Standards for Safer Better Healthcare* in University Hospital Limerick on 30 January 2025.

Section B: Further observations and findings from the monitoring activity of HSE services in HSE Mid West.

Section A: Report of the inspection against the *National Standards for Safer Better Healthcare* in University Hospital Limerick on 30 January 2025

How we inspect

The Health Act 2007, Section 8(1)(c) confers 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 as part of 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, information submitted by the provider, unsolicited information and other publicly available information.

During the inspection, the inspectors:

- spoke with people who used the service to ascertain their experiences of receiving care in the emergency department and on trolleys in inpatient wards
- 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 emergency department
- observed care being delivered, interactions with people who used the emergency department and other activities to see if it reflected what people told inspectors during this inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during this inspection.

The following information outlines some additional data on the hospital

Model of hospital	4
Number of beds	538 inpatient capacity 125 day-case capacity

About the inspection report

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

2. Quality and safety of the service

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

A full list of the four national standards assessed as part of this inspection and the resulting compliance judgments from this and previous HIQA inspections are set out in Appendix 1 and 2 of this report.

Information about this inspection

Similar to previous inspections, this inspection of urgent and emergency healthcare services focused on four national standards from four of the eight themes of the national standards. The inspection team visited the following clinical areas:

- emergency department including the clinical decision unit (CDU)
- geriatric emergency medicine unit (GEMU)
- older persons assessment unit (OPAU) and acute medical unit (AMU)
- acute surgical assessment unit (ASAU)
- discharge lounge
- all inpatient wards where admitted patients were receiving care on trolleys.

The inspectors visited the inpatient areas where patients were accommodated on trolleys. The aim was to review the physical environment that care was delivered in and to speak with patients about their experiences of receiving care while on trolleys. In addition, HIQA also assessed arrangements at the hospital outside of core working hours to confirm the staffing

arrangements and speak with staff delivering care in the emergency department during those hours.

During this inspection, the inspection team spoke with the following staff:

- Members of the HSE Mid West Acute Services Executive Management Team (EMT):
  - Chief Executive Officer (CEO) for Mid West Acute and Older Persons Services
  - Head of Operational Services
  - Chief Director of Nursing and Midwifery (CDONM)
  - Regional Clinical Director
  - Human Resource Manager
  - Director of Quality, Risk and Patient Safety Clinical Director for UEC directorate
  - Director of Nursing (DON) for UEC directorate.
- Head of Bed Management.

Inspectors also spoke with nurse managers, medical staff, nursing staff, support staff and patients receiving care in the hospital's emergency department and in inpatient wards. Inspectors reviewed a range of documentation, data and information received during and after the on-site inspection.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In particular, HIQA would also like to thank the patients who spoke with inspectors about their experiences of the care received.

What people who use the emergency department told inspectors and what inspectors observed in the department

University Hospital Limerick's emergency department configuration and layout was unchanged from HIQA's previous inspections, with four triage rooms, a resuscitation area (seven treatment areas), zones A (seven treatment areas), B (seven treatment areas) and C (five treatment areas), a 12 bedded CDU and a designated paediatric area. Similar to previous inspections, during this inspection, the hospital was in escalation and the emergency department was operating above its planned capacity of 49 treatment bays. Patients were receiving care in designated treatment areas and on trolleys located on the main corridors. The emergency department appeared less congested and the number of patients receiving care on the corridors was considerably less than the numbers seen during previous inspections in 2022 and 2023. The EMT had directed that a maximum number of 20 patients were to be located on the emergency department corridors. Staff who spoke with inspectors were aware and supportive of the efforts to decongest the emergency department and were committed and motivated to achieving that goal.

Staff were observed actively engaging with patients in a respectful, empathetic and kind way. Staff attempted to promote and protect patients' privacy and dignity. However, similar to previous inspections, the environment and context that care was delivered in made it extremely difficult to promote and protect patients' privacy, dignity and confidentiality.

Patients that inspectors spoke with in the emergency department and inpatient wards described staff as "very good" and "doing their best". Similar to previous inspections, patients that were receiving care on trolleys were appreciative of the care received but referenced the environment in which care was being delivered. Patients described how the bright lights, constant noise and activity made it difficult to get any rest while on trolleys in the emergency department and in inpatient wards.

All patients on trolleys in the emergency department and inpatient wards were risk assessed to determine their suitability to be placed on a trolley and assess their individual needs to inform care planning. The 43 patients accommodated on trolleys in inpatient wards were all independent and could mobilise unaided, but nonetheless, the positioning of the trolleys was not conducive to maintaining patients' privacy, dignity and confidentiality. The length of time these patients spent on a trolley in an inpatient ward varied from 12 hours to 72 hours. Patients that inspectors met with did not know about the hospital's complaints process, but all said they would speak to a member of the nursing staff if they had a complaint or concern.

During this inspection, it was clear that there was a focus on decongesting the emergency department, and driving operational and process improvements to enable efficient patient flow through the emergency department and at wider hospital level. On a positive note, this had resulted in less patients receiving care on trolleys on the corridors in the emergency department, but conversely, more patients were receiving care on trolleys in inpatient wards. The continuation of the practice of delivering care to patients on trolleys for a prolonged length of time remains a significant risk to patients, which hospital management needs to continue to manage and mitigate.

Capacity and Capability Dimension

Inspection findings in relation to the *Capacity and Capability* dimension are presented under two national standards (standard 5.5 and standard 6.1) from the two themes of *Leadership, Governance and Management* and *Workforce*. Key inspection findings informing judgments on compliance with these two national standards are described in the following sections.

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

Since HIQA's last inspection in November 2023, a number of significant changes had occurred at hospital and HSE level to align with the corporate and clinical governance arrangements in the new Regional Health Area configuration.

At regional level, the ULHG and CHO governance structures were reconfigured and integrated to align with HSE Mid West structures. There was a defined reporting arrangement to the HSE Mid West's Regional Executive Officer (REO) who was accountable and responsible for the operational service delivery in the Mid West Region of Ireland. The REO reported directly to the HSE's CEO. The HSE Mid West comprised three areas:

- acute and older people services
- Clare and Limerick county Integrated Healthcare Area (IHA)
- Limerick City and North Tipperary IHA.

Accountability and responsibility for operational service delivery and the integration of acute and older person's services was assigned to the CEO for Mid West Acute and Older Persons Services (referred to as CEO), who was appointed in October 2024. IHA managers were responsible for the integration and delivery of services in the two IHAs — Clare and Limerick county, and Limerick City and North Tipperary areas.

At hospital level, the hospital's corporate and clinical governance arrangements had recently changed to align with the HSE's reconfigured and realigned structures. Overall responsibility and accountability for the operational delivery of urgent and emergency healthcare services in University Hospital Limerick and other acute hospitals in HSE Mid West lay with the CEO. The configuration of the hospital's EMT had changed since the previous inspection in 2023. Members of the updated EMT were clear about and understood their roles and areas of responsibility. The EMT supported and assisted the CEO in ensuring and assuring the quality and safety of urgent and emergency healthcare services and that the agreed objectives and performance requirements for those services were delivered. In previous inspections, the EMT were based off site but during this inspection they were based in University Hospital Limerick. On this inspection, staff who spoke with inspectors said that there was a strong visibility and on-site presence of the EMT. This together with centralised operational processes and controls enabled the EMT to have good operational grip and robust governance and oversight over the operational delivery and quality of urgent and emergency healthcare services across HSE Mid West 24/7.

The EMT worked cohesively and collaboratively to ensure there was a concerted focus to deliver sustainable operational efficiencies and process improvements that would de-escalate and reduce overcrowding in the emergency department, and improve patients' experiences and the hospital's overall performance with quality metrics and patient experience times

(PETs).[*] The CEO and EMT were clear and definitive about the need to manage urgent and emergency healthcare services. They particularly focused on the activity, performance and resourcing of those services. There was a specific focus on ensuring compliance with the 24-hour PET and on ensuring the timely assessment and early access to specialist emergency and geriatric medicine for patients aged 75 years and over. This aligned with the targeted actions in the HSE's operational plan for urgent and emergency care.

There was strong oversight and accountability systems in place to ensure and assure the quality, safety and reliability of urgent and emergency healthcare services. Decision-making, responsibility and accountability for urgent and emergency healthcare services was devolved to executive and operational managers with clearly defined reporting arrangements and accountability to the CEO. All staff who spoke with the inspectors were clear about and understood their roles and areas of responsibility. The UEC directorate's leadership team comprised a clinical director, DON and general manager, who was accountable and responsible for the strategic and operational governance of all urgent and emergency healthcare services across HSE Mid West. This included the emergency department, MAUs and injury units in Nenagh Hospital, Ennis Hospital and St John's Hospital. The UEC directorate reported on the quality and performance of those services to the Quality and Safety Executive Committee (QualSEC), who in turn provided the EMT with assurances about the quality of those services. The EMT reviewed information about the demand for urgent and emergency healthcare services and the service's performance with specified quality metrics monthly. HSE Mid West plans to publish this cumulative information so that patients, relatives and the general public will have sight of the quality of healthcare services across the region.

The demand for urgent and emergency healthcare services in the Mid West Region of Ireland increased by 10.4% in 2024 when compared to 2023 activity. On the day of inspection, the hospital was in full escalation, working at 105% capacity in terms of overall bed occupancy, with the emergency department operating well above its planned capacity. This was in the context that in the week preceding this inspection (week of 20-27 January 2025), 252 to 334 people attended the emergency department daily, averaging 280 people per day – an extremely high level of presentations when compared to other Irish emergency departments. Nationally, University Hospital Limerick reported the second-highest number of emergency department presentations and highest level of emergency department admissions for 2024.

Effective operational planning by the EMT supported the proactive anticipation and management of the day-to-day demand for urgent and emergency healthcare services across HSE Mid West. There was a robust, comprehensive whole system plan to manage the demand and to maximise the efficiencies of processes so that there was timely access to senior decision-makers,[†] appropriate hospital admission avoidance and minimisation of delays for inpatient beds. This plan, called the Seasonal Service Level Adjustment Plan (SSLAP),

[*] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

[†] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

comprised clearly defined actions. These actions were embedded in local hospital operational structures and delivered within a comprehensive whole system, regional approach on a phased basis over 15 weeks. The hospital's escalation processes were revised and simplified to align with the plan. During this inspection, there was evidence that actions in the plan were being implemented to support operational efficiencies, increase capacity and ensure effective patient flow. Specific surge measures were being implemented for an agreed time to improve patient flow and mitigate patient safety risks arising from the pressures for urgent and emergency care. These included:

- the pausing of all inpatient scheduled care with the exception of time-sensitive cancer cases in the five acute hospitals in HSE Mid West
- using all inpatient beds arising from the pausing of scheduled care as surge beds for medical patients from University Hospital Limerick
- prioritising inpatient diagnostics in University Hospital Limerick
- the pausing of regular outpatient clinics in all acute hospitals in HSE Mid West, with the medical staff redeployed to the emergency department and other assessment areas (OPAU and ASAU) in University Hospital Limerick
- the rostering of additional medical consultants at weekends to enable efficient post take rounding and decision-making on patient discharge or transfer (see national standard 6.1)
- increasing surge capacity across all five acute hospitals in HSE Mid West.

The effectiveness of the actions in the SSLAP was monitored by the EMT and UEC directorate and was measured against the following key performance indicators (KPIs):

- triage times of 25 minutes or less
- management of the Manchester Triage System levels in line with the relevant assessment times (Level 1-immediate; Level 2-very urgent (10 minutes); Level 3-urgent (60 minutes); Level 4-standard (120 minutes); Level 5-non-urgent (240 minutes)
- 20 patients or less to be accommodated on the emergency department corridors (the inspectors were informed that this was to be revised downwards to 15 patients or less in the weeks following inspection)
- no breaches in the over 75 years of age 24-hour PETs
- reduction in all breaches of 24-hour PETs
- 15 or less admitted patients located on corridors in the emergency department at 8am
- reduction of the number of patients with a 20 days or more length of stay
- 10 or less delayed transfer of care (DTOC) in University Hospital Limerick
- a maximum number of 44 trolleys in inpatient wards
- a minimum of 17 clinically suitable patients transferred daily from University Hospital Limerick to the other four acute hospitals in HSE Mid West – Nenagh Hospital, Ennis Hospital, St John's Hospital and Croom Orthopaedic Hospital.

Evidence of compliance with the above KPIs was seen during this inspection and in the hospital's data performance report for 2024. For example:

- 20 (24%) of the patients in the emergency department were admitted awaiting an inpatient bed, an improvement on the number of patients reported during previous inspections (60 patients in February 2022; 55 patients in February 2023 and 35 patients in November 2023)
- 91.9% of patients were in the emergency department for less than 24 hours, an improvement on the 77% reported in November 2023, but less than the HSE national target of 99%
- the median PETs for admitted patients had improved (see Table 1).

Table 1: Comparison of Median Patient Experience Time in 2022, 2023 and 2025

Year	Total median PET time	Admitted patient median PET time	Non-admitted patient median PET time
2022	9.6 hours	14.1 hours	7.6 hours
2023	5.6 hours	12.33 hours	4.38 hours
January 2025	6.0 hours	9.9 hours	5.1 hours

Overcrowding of the emergency department and wider hospital was apparent on the day of inspection, with 20 patients receiving care on the emergency department's corridor and 43 patients receiving care on trolleys in inpatient wards. The numbers on trolleys in inpatient wards was less than the number agreed by the EMT as part of the escalation process (44 trolleys). Eight (19%) patients receiving care on trolleys in inpatient wards were waiting for diagnostics. The majority of these patients were waiting for an inpatient bed and review by the specialist medical team and or health and social care professionals (HSCPs). Some patients had been discharged.

There was a systematic approach to overseeing and managing the hospital's responsiveness to meet the demand and pressures for urgent and emergency healthcare services. A series of meetings were held daily and weekly that focused on unscheduled and scheduled care activity, capacity and patient flow. Formalised, integrated and coordinated working relationships with community services in HSE Mid West supported the efficient flow and timely discharge or transfer of patients from the hospital.

Evidence of operational efficiencies to support better patient flow can be seen in the higher levels of patient discharge at weekends and bank holidays. Over the February bank holiday (the weekend after this inspection), University Hospital Limerick had the highest number of patient discharges (268 patients) per bed capacity when compared to other Model 4 hospitals (see Table 2).

Table 2: Number of Patient Discharges per Bed Capacity over the February Bank Holiday Weekend 2025

Hospital	Bed Numbers (Inpatient and day case beds)	Total Discharges over Feb. Bank Holiday Weekend	% of Overall Bed Number
University Hospital Limerick	**663**	**268**	**40.4%**
Beaumont Hospital	914	197	21.5%
Cork University Hospital	755	194	25.6%
St James Hospital	1,201	193	16%
Mater Misericordiae Hospital	950	145	15.2%
Tallaght University Hospital	585	167	28.5%
St Vincent's University Hospital	635	200	31.4%
Galway University Hospital (incl. Merlin Park Hospital)	891	136	15.2%
University Hospital Waterford	511	124	24.2%

In the context of University Hospital Limerick's bed capacity, the EMT were aware that substantial operational efficiencies, with a continuous focus on process improvements of unscheduled care was needed and that this involved some degree of a trade-off with scheduled care. During this inspection, the majority of the hospital's inpatient beds were occupied by medical patients. The EMT were aware of the actual and longer-term potential impact that the imbalance between the delivery of unscheduled and scheduled care was having on care delivery and were committed to addressing the imbalance whenever possible. Given the continuing state of escalation at the hospital, the imbalance is set to continue for the short and medium-term.

Optimising and increasing the hospital's inpatient bed capacity was a priority. A new 16-bed block was opened at the hospital in December 2024. A 96-bed block referenced in previous inspection reports is due to be operational in quarter three (Q3) of 2025. On previous inspections, there was an intention to designate 44 of the 96 beds as replacement beds and the remaining 52 beds would be additional bed stock. At the time, HIQA questioned if this was the most efficient use of this new resource given the risks posed by persistent gross overcrowding in the emergency department. HIQA welcomes the change in plan and decision that all 96 beds will now be additional to the hospital's current inpatient bed stock. Collectively, these new beds will add another 112 inpatient beds to the hospital's bed stock. The hospital's inpatient capacity will be further enhanced when the off-site surgical hub and a further second, on-site 96-bed block are built and come online. HIQA also notes that the Department of Health recently published the *Acute Hospital In-patient Bed Capacity Expansion Plan 2024-2031*. This committed a further 198 new beds across HSE Mid West — 84 beds new beds for University Hospital Limerick, 42 new beds for St John's Hospital, 48 new beds for Ennis Hospital and 24 new beds for Nenagh Hospital.

Several service improvements and or service reconfigurations have occurred since November 2023 to improve the way acute care is organised in University Hospital Limerick. This included

the expansion of GEMU, the implementation of the virtual ward, the re-instatement of the discharge lounge and the repurposing of the hospital's 23-bedded AMU to incorporate two assessment areas — an assessment unit for older persons (16 beds) and a nine-bedded area for patients requiring short-term acute medical care. Both assessment areas operated 24/7. The establishment of the assessment unit for older persons provided a dedicated care pathway for elderly patients whose care was better managed outside the emergency department environment. It supported the timely assessment and intervention of patients aged 75 years and over streamed from the emergency department, with input from the multidisciplinary teams working in GEMU, the community intervention team (CIT) and the Integrated Care Programme for Older People (ICPOP). The nine acute medical beds in the AMU supported the early specialist management of medical patients who met a defined criteria and required short-term (48 hours) medical care under the governance of the medical directorate. Patients for the acute medical beds were referred from the emergency department or directly from primary care services. The repurposing of the AMU had resulted in the reduction of beds for acute medical patients. Consequentially, this impacted on the ability to maximise capacity for same-day discharge and or reduce the length of stay for medical patients requiring short-term acute medical care.

Patients requiring acute surgical assessment and who met a defined criteria were referred to the ASAU from the emergency department and or primary care services. The ASAU operated 24/7 and had a planned capacity of 24 treatment areas. During this inspection, the ASAU was functioning as intended, providing rapid assessment and treatment of a variety of acute surgical conditions under the governance of the peri-operative clinical directorate.

The hospital's 12-bedded CDU was located in the emergency department but at the time of inspection, it was not functioning as intended. The unit was a designated area for patients who presented to the emergency department but were not fit for immediate discharge and required either short-term low complexity treatment, low-acuity interventions (such as further observations or diagnostics) and or specialist review. Patients in CDU were monitored and treated for a short period of time (usually for six to 24 hours), according to disease-specific protocols under the care of a consultant physician specialised in emergency medicine. During this inspection, there were 15 patients in CDU — 12 in designated treatment areas and three patients accommodated on trolleys on the corridor. Half of the patients were admitted awaiting an inpatient bed. Consequently, the ability to efficiently manage patients requiring short-term, low-acuity interventions and or treatment was hindered.

The hospital's discharge lounge closed during the COVID-19 pandemic because it did not conform to the required infection prevention and control standards. It was reinstated in November 2024. It operated Monday to Friday (8am to 3pm) and comprised seven armchairs accommodating patients who were medically discharged from the hospital but were awaiting transfer home or to another care setting. The intention of the discharge lounge was to free up inpatient beds as early as possible, maintain efficient patient flow and help reduce the length of time patients waited for inpatient beds. Since its opening, the discharge lounge has accommodated an average of 50 patients per week.

In summary, since March 2022, there has been significant improvement in compliance with this national standard. During this inspection, there were clearly defined, responsive and effective management arrangements in place at hospital and regional HSE levels to support and promote the delivery of urgent and emergency healthcare services. There was a definite focus on finding solutions to drive operational and process improvements to achieve more efficient patient flow and decongest the emergency department. There was a focus on improving the 24-hour PET and on ensuring assessment and early access to specialist emergency and geriatric medicine for patients aged 75 years and over. Actions to manage periods of demand and surge were simplified and clearer when compared to findings from previous inspections. There was good visibility and on-site presence of the EMT, which supported operational grip 24/7. There was a greater focus on devolved accountability for executive and operational managers. There was an uplift in the inpatient bed stock and HIQA welcomes the decision that all 96 beds in the new bed block coming online in Q3 of 2025 will be used to bring the hospital's inpatient capacity closer to the projected beds required. Given the continuing escalation at the hospital and the balancing of the risk that is needed in that context, it is likely that scheduled care activity may continue to be severely impacted by the need to divert bed capacity for unscheduled care needs. The EMT was acutely aware of the actual and potential impact that this arrangement had on scheduled care and was committed to addressing it whenever possible. It was evident that the operational efficacies and process improvements that have occurred since March 2022 have resulted in improved performances, especially in the 24-hour PET. While this is to be welcomed, it is imperative that these improvements are maintained, sustained and built upon to further support and promote the delivery of high-quality, safe and reliable urgent and emergency healthcare services in HSE Mid West. Noting the context within which healthcare services were being managed – in particular the ongoing significant mismatch between demand and capacity – HIQA is of the view that recently revised and enhanced management arrangements were working as effectively as might reasonably be expected to address the risks at hand at the current time. In the short term, it is imperative that these risks continue to be alleviated effectively as new capacity is added at the hospital over the course of 2025.

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.

At the time of this inspection, the hospital's workforce arrangements were planned, organised and managed to support and ensure the delivery of urgent and emergency care 24/7. A consultant in emergency medicine had clinical oversight and was responsible for the day-to-day operational functioning of the emergency department. A clinical nurse manager, grade 3 (CNM 3) oversaw the operational nursing functions in the emergency department Monday to Friday and reported to the DON for the UEC directorate and operational assistant director of nursing (ADON). A shift leader at CNM 2 grade was rostered 24/7 to operationally manage the

emergency department and ensure sufficient patient flow during each shift. Staff resources in the emergency department was a high-rated risk recorded on the hospital's risk register. Staff redeployment and the prioritisation of frontline clinical posts were actions applied to manage and mitigate the risks arising from shortfalls in staff resources.

There was a total of 188 whole-time equivalent (WTE)[‡] medical consultants across a range of specialties employed in the hospital, with a plan to regularise a further 63 WTE consultant posts (existing and newly approved positions) across a range of specialities. The hospital had 14 WTE consultants in emergency medicine, with these positions filled on a permanent (12 WTE) or temporary (2 WTE) basis. This represented an increase of 3 WTE consultants in emergency medicine since February 2023. All permanent consultants in emergency medicine were on the relevant specialist division of the register with the Irish Medical Council. The on-site presence of consultants in emergency medicine had increased and improved compared to November 2023. Senior clinical decision-makers at consultant level were now on site seven days a week in the emergency department from 8am to 10pm Monday to Friday and from 8am to 6pm at weekends and bank holidays. Outside these rostered working hours, one consultant in emergency medicine was on call for the emergency department and was located off site (Monday to Friday). Medical consultants from each speciality provided on-call cover for the rest of the hospital. A second consultant in emergency medicine was rostered on call at weekends and bank holidays to meet the expected increase in demand for urgent and emergency healthcare services. All on-call consultants were rostered to be on site for a period of time to enable ward rounding, patient review, discharge planning and clinical handover. In addition, specialty consultants carried out daily rounding of admitted patients in the emergency department and in surge beds or trolleys to expedite decision-making, treatment and where appropriate, patient discharge. The increased on-site presence of senior decision-makers at consultant level in the emergency department and across the hospital, especially outside core working hours, have resulted in greater operational efficiencies, as evident in higher levels of patient discharge over the February bank holiday weekend (see Table 2). The percentage of patients admitted to the hospital (conversion rate) over the February bank holiday weekend was consistent with hospital's overall conversion rate of 32%. Admission and conversion data was monitored daily by the EMT.

The hospital was funded for 56 WTE NCHDs in emergency medicine. Fifty WTE (89.29%) of the 56 NCHD positions were filled at specialist registrar (6 WTE), registrar (15 WTE) and senior house officer (29 WTE) grades. The remaining 6 WTE (10.71%) NCHD positions were unfilled, but during this inspection, there was an active recruitment campaign underway to fill these positions. Overall, compared to November 2023, there was an uplift of 9 WTE NCHDs working in the emergency department and the number of NCHD positions unfilled had decreased compared to the 20% reported in November 2023. NCHDs were assigned to work in specific zones or areas of the emergency department and were responsible for the clinical care and management of patients in that zone or area. At the time of inspection, a

[‡] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

recruitment campaign was also underway to fill two new NCHD positons at registrar grade for the new Swift Assessment and Treatment (SWAT) and Emergency Department in The Home (EDITH)[§] service-development initiatives.

The emergency department was funded for 187.75 WTE nurses (including management and other grades), an increase of 63.95 WTE when compared to November 2023 (123.8 WTE). This included 14.0 WTE nurses exclusively for admitted patients accommodated in the emergency department and 23.79 WTE nurses for GEMU. Table 3 presents the nurse staffing WTE and reported variance in the approved and actual WTE during this and in previous HIQA inspections. The emergency department's overall approved nurse staffing WTE had increased substantially since March 2022. The current approved WTE (187.75 WTE) represented an increase of 56% (67.39 WTE) since March 2022. During this inspection, there was a 25.20% (51.64 WTE) variance between the approved and actual nurse staffing WTE, similar to the variance in other Model 4 hospitals (Mater Misericordiae University Hospital). However, in total terms, the emergency department's nurse staffing WTE had increased by 56% (approved) and 29% (actual) since March 2022.

Table 3: Nurse Staffing WTE in Emergency Department 2022, 2023 and 2025

Nurse Staffing WTE in the Emergency Department			
Year	Approved WTE	Actual WTE	Variance WTE/%
March 2022	120.36	105.12	15.24 WTE (13%)
February 2023	125.79	91.17	34.62 WTE (27.57%)
November 2023	123.8	100.6	23.2 WTE (18.7%)
January 2025	187.75	136.11	51.64 WTE (25.50%)

The total WTE included the uplift of nurses arising from the implementation of phase one of the Department of Health's safe staffing framework. Phase one of the framework focused on the safe staffing requirements for adult general and specialist medical and surgical care settings. The second phase of the framework focused on the safe staffing requirements for adult emergency care settings. During this inspection, phase two was not implemented in University Hospital Limerick or across the wider healthcare setting, but the HSE had planned to progress its implementation in 2025. The advanced nurse practitioner (ANP) model of care supported the delivery of care to patients attending the emergency department with low-acuity chronic illness. Five (62.50%) of the department's 8 WTE ANP positions were filled. National and international recruitment campaigns were underway to fill the vacant nursing positions, including the ANP positions and a clinical nurse specialist (CNS) position for the newly introduced EDITH pathway, and to adequately resource the new 96-bed block when it is operational in Q3 of 2025. During this inspection, the emergency department had its full rostered number of nurses on duty. When nursing staff shortfalls occurred, they were

[§] Emergency Department in The Home (EDITH) is a frailty response service, providing emergency medical and occupational therapy to adults aged 65 years and over.

managed through staff redeployment, overtime or the employment of agency staff. The increase in nursing staff enabled a different operational approach to delivering nursing care to be implemented in the emergency department, with the aim of improving care delivery and increasing nursing staff agility and flexibility. A team of nurses was assigned to each zone or area of the department, who together with a nominated team leader and supported by a CNM 2 and CNM 1, delivered nursing care in that zone or area. A CNM 2 shift leader was rostered 24/7 to operationally manage the emergency department and ensure the effective and efficient flow of patients. There were no issues reported to the inspectors in terms of the emergency department's nursing skill mix, with 48% of nurses reported to be between 5 and 10 years qualified and 51% of nurses reported to be less than five years qualified. Clinical skills facilitators (CSFs) supported nursing staff to maintain the requisite skills and competencies needed for working in the emergency department; 50% of the approved CSF positions were filled at the time of inspection.

Table 4 presents the healthcare care assistants (HCAs) WTE and reported variance in the approved and actual WTE during this and in previous HIQA inspections. The emergency department's overall approved HCA staffing WTE had increased, with the current approved WTE (47.76 WTE) representing a substantial increase of 41.76 WTE since March 2022. During this inspection, there was a variance of 23.19 WTE (48.55%) between the approved and actual HCA staffing WTE but in total terms, there had been a gain in the approved (gain of 48.55 WTE) and actual (gain of 18.57 WTE) HCA staffing WTE since March 2022.

Table 4: Healthcare Assistant WTE in Emergency Department 2022, 2023 and 2025

Healthcare Assistant WTE in the Emergency Department			
Year	Approved WTE	Actual WTE	Variance WTE/%
March 2022	6	6	None
February 2023	29.26	19.66	9.6 WTE (32.81%)
November 2023	29.26	22.38	6.88 (23.51%)
January 2025	47.76	24.57	23.19 (48.55%)

The emergency department and inpatient wards in University Hospital Limerick were exempt from the HSE's recruitment pause (introduced in 2024) that other health service providers had to maintain. However, the HSE Mid West, as a whole, was subject to the recruitment pause and revised WTE. Daily fundamentals of care audits provided assurances about the quality of nursing care delivered in the emergency department and identified the impact any nursing and HCA staff shortfalls had on care delivery.

Patients in the emergency department, especially those in the older age group and those receiving care in GEMU, had access to a range of HSCPs. The emergency department had its approved number of occupational therapists (4 WTE) and dieticians (1 WTE), but two thirds of the medical social worker positions and 37.5% of the physiotherapist positions were unfilled. These shortfalls impacted on the timely assessment and intervention for patients

attending the emergency department, but the focus was maintained on prioritising patients aged 65 years and over and those presenting with frailty.

The emergency department had an assigned clinical pharmacist. Half (20.55 WTE) of the hospital's funded 41.35 WTE pharmacist positions and 4.9 WTE (17.68%) pharmacy technician positions were unfilled. The staffing shortfalls in the pharmacy department affected the ability to deliver a comprehensive pharmacist-led clinical pharmacy service in the emergency department. Pharmacist-led medication reviews and medicines reconciliation was prioritised for admitted patients waiting in the emergency department for an inpatient bed.

Nursing and medical staff in the emergency department undertook mandatory and essential training appropriate to their scope of practice. Staff uptake and attendance at mandatory and essential training was monitored with oversight by the CNM 3 and CSFs. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record system. Staff confirmed that they had received formal induction training on commencement of employment. Nursing staff had access to and were required to complete training in infection prevention and control, medication safety and the early warning systems on the HSE's online learning and training portal (HSELanD). The emergency department's staff training records, reviewed by inspectors, showed that there was a good uptake of essential and mandatory training by staff. Training records showed that:

- all nurses, HCAs, medical staff and HSCPs were compliant and up to date with training in hand hygiene, transmission-based precautions and standard-based precautions
- all nurses were up to date with training in the early warning systems
- 99% of nurses were up to date with training in basic life support
- all nurses and 25.40% of medical staff were up to date with training in clinical handover.

The hospital's staff absenteeism rate was tracked, trended and reported monthly to the EMT and HSE. The trend for 2024 was consistent with the absenteeism rates reported in previous inspections. During this inspection, the average staff absenteeism rate (7.3%) was above the HSE's target (4% or less). There was a proactive focus on promoting the health and wellbeing of staff, with a range of wellbeing initiatives, occupational health supports and a psychologist available to staff. Staff recruitment campaigns were ongoing and there was an active recruitment campaign underway to ensure appropriate staff resourcing of the new 96-bed block due to come online in Q3 of 2025.

In summary, there has been a significant uplift in the emergency department's staff numbers and pattern of working over the past three years, since March 2022. Compliance levels with this national standard have improved incrementally over that period of time too. During this inspection, there were variances between the approved and actual nurse and HCA staffing WTEs. Notwithstanding this, since March 2022, there has been a substantial increase in the approved (56%) and actual (29%) nurse staffing WTE. Likewise, there has been a substantial increase in the approved (48.55 WTE) and actual (18.57 WTE) HCA staffing WTE. Noting the substantial increase that has occurred and the ongoing variance between the approved and

actual nurse and HCA staffing WTE, a focus on implementing phase two of the safe staffing framework for the emergency department will further support and ensure sufficient staff resources and skill mix in the department. In the interim, until the HSE implements phase two of the safe staffing framework, it is imperative that the risks arising from any variance in staff WTE continues to be managed effectively until such time that the additional staff from the various recruitment campaigns that were underway during this inspection join the workforce. The subsequent changes in work practices arising from the increase in staff resources have enabled a greater on-site presence of senior decision-makers at consultant level, especially outside core working hours, seven days a week, and have facilitated a different approach to nursing care delivery. Nonetheless, the reported staffing shortfalls in the hospital's pharmacy department did affect the ability to deliver a comprehensive clinical pharmacy service for patients in the emergency department. This presented a patient safety risk that was being managed effectively at the time of inspection through staff redeployment, overtime and or the employment of agency staff. Staff recruitment campaigns were also underway and it was reported to the inspectors that the campaigns have been successful in filling nursing and medical positions. With the additional inpatient bed capacity coming online and the associated revised uplift of staff needed to meet the increased bed allocation, more long-term, sustainable measures will need to be taken to address any current and possible future staff shortfalls.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings related to the *Quality and Safety* dimension are presented under two national standards (standard 1.6 and standard 3.1) from the two themes of *Person-centred Care and Support* and *Safe Care and Support*. Key inspection findings informing judgments on compliance with these two national standards are described in the following sections.

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

Staff working in the emergency department were focused and committed to promoting a person-centred approach to care. Staff were united in their determination and motivated in their drive to do their best for the patients and to deliver high-quality care. During this inspection, staff were observed being kind and caring, and speaking with patients in a reassuring way. Staff were observed being supportive and responsive in meeting patient's most urgent needs and preferences. There was a focus on protecting patients' privacy and dignity. However, the physical environment, capacity constraints, numbers of patients and the well-documented overcrowding in the emergency department made it difficult for staff to meaningfully promote patient's dignity and privacy. In the context of a very busy emergency

department that was continually operating above its planned capacity and in a constant state of escalation, patients' privacy and dignity was compromised. By way of example, during this inspection, the inspectors regularly overheard medical staff talking and discussing private and sensitive information with patients accommodated on trolleys the corridor.

Patients requiring additional support and assistance were identified and reviewed regularly throughout the day during the emergency department huddles. Actions were implemented to support and ensure patients were appropriately supported with their individual needs. Staff prioritised the placement of older and vulnerable patients and patients with specific care needs, such as those attending oncology or haematology services. Patients at end of life were also prioritised for a single room. Families and relatives of patients receiving end-of-life care had access to a dedicated bereavement area within the emergency department. A cubicle was kept free and used when delivering intimate clinical care, which provided patients with some degree of privacy. Portable screens were used to give a degree of privacy when care was delivered to patients accommodated on trolleys on corridors.

The inspectors spoke with patients who were accommodated on trolleys on corridors in the emergency department and in inpatient wards. All patients accommodated on trolleys in inpatient wards could mobilise independently and all considered the move to an inpatient ward, albeit on a trolley, as a sign their care had progressed from the emergency department. These patients were not accommodated in a dedicated patient bed space and they had nowhere to store their personal belongings. The appropriateness of patient placement was reviewed regularly throughout the day at nursing handover. Measures were taken to mitigate any actual and potential risks for patients accommodated on trolleys on corridors in the emergency department and in inpatient wards. For example, patients were issued with call bells so they could call for assistance when needed and nurses, HCAs and members of the hospital's patient advocacy and liaison service (PALS) team regularly and systematically followed up with patients to address their individual needs. HCAs and the PALS team provided comfort measures and assisted patients with their hygiene and other specific, individual needs. Access to shower facilities for patients on trolleys was insufficient. Patients were provided with comfort and toiletry packs. Daily fundamentals of care audits provided assurances that the support and quality of nursing care provided in the emergency department was at the expected level and met patient's expectations. Quality improvement actions were implemented when care fell below expected standards.

In summary, the number of patients receiving care on trolleys on corridors in the emergency department had decreased from previous inspections in 2022 and 2023 but conversely, more patients were accommodated and receiving care on trolleys in inpatient wards. Patients requiring higher levels of support and assistance were placed in designated treatment areas. Measures were in place to promote patients' privacy and dignity, but the overall situation and judgment of non-compliance was the same as previous inspections in 2022 and 2023:

- patients' dignity, privacy and confidentiality was compromised

- staff were acutely aware and were doing their best to promote patients' privacy, dignity and confidentiality but were constrained by the circumstance and conditions in the emergency department
- measures were applied to mitigate the risks to patients accommodated on trolleys on corridors or outside designated treatment areas, but the practice conflicts with a human rights-based approach to care.

Judgment: Non-compliant

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

As per previous inspections, information about the delivery of urgent and emergency healthcare services was monitored and analysed, and actions were implemented to mitigate any actual and potential risks to patient safety. Information was collated on a range of quality metrics including the number of attendances, discharges and admittance from the emergency department, PETs, attendance to the MAUs and injury units, patients' average length of stay (ALOS) and DTOC numbers. The collated information and corrective measures to improve performance was reviewed and discussed at monthly EMT meetings.

Risks to patients attending the emergency department were managed according to the hospital's risk management policy, with appropriate governance and oversight by QualSEC and EMT. Serious risks that could not be managed at emergency department level because of the level of actions required were escalated to the EMT and UEC directorate's serious incident management team (SIMT), and recorded on the directorate's and or hospital's risk register. Overcrowding and staff resourcing were two high-rated risks related to the emergency department that were being managed at the time of inspection. Appropriate controls and corrective actions were applied to mitigate these risks. For example, the pausing of scheduled care supported the redeployment of NCHDs to the emergency department to support the timely triage, assessment and management of patients.

On the day of inspection, as per previous inspections, the hospital was in full escalation. A total of 87,336 people attended the emergency department in 2024, equating to an average of 7,281 attendances per month or 239 attendances per day. This daily number was surpassed during the week of this inspection, with an unprecedented 334 attendances to the emergency department. During this inspection, at 11am, 83 patients were registered in the emergency department, almost double the department's planned capacity. Twenty (24%) of these patients were admitted while waiting for an inpatient bed, which was lower than the numbers reported in previous HIQA inspections (see Table 5). Admitted patient's length of stay in the emergency department was a risk noted during this and previous HIQA inspections. The admitting medical or surgical team had clinical governance over and were responsible for the clinical care of admitted patients in the emergency department. Non-

urgent clinical care was provided by the admitting medical team, with nursing care provided from the complement of nursing staff in the emergency department.

Table 5: Number of Admitted Patients Awaiting an Inpatient Bed in the Emergency Department during HIQA Inspections in 2022, 2023 and 2025

Number of Admitted Patients Awaiting an Inpatient Bed in the Emergency Department		
Year	Numbers Admitted Awaiting Inpatient Bed	% of the Total Number of Patients Registered in ED
March 2022	60	43%
February 2023	55	45%
November 2023	35	38%
January 2025	20	24%

Clinical governance and responsibility for non-admitted patients receiving emergency care lay with the emergency medicine clinicians. Patients attending the emergency department were assessed, triaged and categorised in line with the Manchester Triage System. A consultant in emergency medicine was allocated to triage during core working hours, facilitating acute assessment by a senior decision-maker at consultant level. Additional nursing and medical staff resources were allocated to triage to achieve the 25 minutes or less triage time KPI. Compliance with this KPI was audited daily, with a 63.15% compliance rate noted in a sample of audits reviewed by the inspectors for the weeks prior to this inspection. Timely triage should continue to be an area of focused improvement to ensure compliance with the triage time recommended by the HSE's national emergency medicine programme (95% of patients triaged within in 20 minutes). Real time information on emergency department activity and performance was readily available for clinicians, executive and operational managers. During this inspection, the average waiting time from:

- registration to triage was 15 minutes (range 6 minute to 28 minutes), an improvement on the average of 25 minutes in November 2023. It was also compliant with the EMT's KPI of 25 minutes and within the 20 minutes recommended by the HSE's national emergency medicine programme
- triage to medical assessment was 37 minutes for non-urgent patients (range 6 minute to 1 hour 52 minutes), a substantial improvement on the average of 2 hours 12 minutes in November 2023
- decision to admit to actual admission in an inpatient bed was 13 hours 35 minutes (range from 2 hours 15 minutes to 55 hours 5 minutes), a substantial improvement on the average of 30 hours 44 minutes in November 2023.

There was a concerted effort to optimise existing inpatient bed capacity across the HSE Mid West. A centralised operational bed management system provided information on all beds

available in HSE-funded hospitals in HSE Mid West. 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. Operational processes were in place to support the discharge of patients before 12pm, seven days a week. Where it was identified that it was clinically appropriate to transfer patients to other services, at least 17 patients were transferred daily to the other four acute hospitals in HSE Mid West — five patients were transferred to Nenagh Hospital, five patients to Ennis Hospital, five patients to St John's Hospital and two patients was transferred to Croom Orthopaedic Hospital. All 17 transfers were utilised daily. A further five patients were transferred daily from the emergency department to Croom Orthopaedic Hospital via the ambulatory trauma pathway. All available rehabilitation, convalescence and or transitional care beds in HSE Mid West were fully utilised. Hospital management had access to surge capacity across HSE Mid West. All surge capacity was utilised when the University Hospital Limerick was in full escalation.

There was a concerted focus on discharge and on reducing patients' length of stay. There was meaningful use of predicated day of discharge and progress in achieving discharge was monitored daily as part of the Red to Green system. Patient's ALOS and DTOC cases were monitored weekly. All cases of extended length of stay (over 10 days) and delayed discharges were reviewed weekly with input from clinical teams and community services, with the aim being to find appropriate solutions to support safe patient discharge.

There was an improved focus on avoiding hospital admission where possible. Clinically appropriate patients were directed and streamed at triage to a range of additional and alternate, admission avoidance services, including:

- MAUs in Nenagh Hospital, Ennis Hospital and St John's Hospital.
- Injury units in Nenagh Hospital, Ennis Hospital and St John's Hospital.
- Ambulatory trauma pathway in Croom Orthopaedic Hospital.
- GEMU, which incorporated OPTIMEND.[‡‡]
- CIT.
- ICPOP community specialist teams.
- Outpatient Parenteral Antibiotic Therapy (OPAT).
- Virtual ward.
- EDITH.
- Limerick Pathfinder service.
- Alternative Pre-hospital Car (APP Car) pathway.

[**] The SAFER bundle comprises five elements of best practice – **S**enior review by a clinician, **A**ll patients have a predicated discharge date, **F**low of patients, **E**arly discharge of patients, **R**eview of patients with extended lengths of stay by multi-disciplinary team (MDT).

[††] The 'Red to Green' approach aims to reduce a patient's length of stay and avoidable delays where a patient may be waiting for things, such as test, investigation and or referrals to happen to progress their care.

[‡‡] A dedicated team of health and social care professionals in the emergency department focusing on the on timely assessment and intervention of people 65 years and older.

The frail elderly pathway (GEMU incorporating OPTIMEND) had strong clinical governance provided by consultants in emergency medicine and geriatric medicine and there was a definitive focus on avoiding hospital admission and reducing length of stay for patients in this pathway. There was in-reach from and outreach to the ICPOP specialist team. Other services such as Limerick Pathfinder[§§] and APP Car[***] had expanded their scope and or the number of patients they saw and treated since HIQA's inspection in November 2023. In 2024:

- 65% of those reviewed by the Limerick Pathfinder team avoided attendance and or admission to an acute hospital (an increase on the 51% non-conveyance reported in November 2023).
- 54% of the patients reviewed by the APP Car team avoided attendance and or admission to an acute hospital (similar non-conveyance rates reported in November 2023).

The virtual ward was a recent service-development initiative, it delivered care for 25 patients in their own home using remote monitoring technology. At the time of this inspection, the virtual ward was working at 100% capacity and since its establishment in July 2024, it has provided care for 325 patients (and saved an estimated 2,000 inpatient bed days). The EDITH service was introduced in January 2025, it provided an alternate care pathway for adults aged 65 years and over, providing emergency medical and occupational therapy to patients in their own home.

Other hospital-based targeted initiatives — OPAU, AMU, ASAU and CDU supported the rapid assessment and timely interventions by appropriate specialist and multidisciplinary teams. The prioritising of inpatient access to diagnostics also enabled effective decision-making, discharge planning and supported efficient patient flow. Multiple operational and patient flow meetings with input from all acute hospitals in HSE Mid West identified any issues with patient discharge and the solutions to appropriately address those issues. Medical staff rounded in the emergency department every morning and evening, which supported decision-making on treatment and discharge planning. There was also a systematic review of all patients with extended length of stay. Other initiatives that were to be applied as part of the compliance plans from previous inspections — the establishment of a telemetry hub and the reconfiguration of healthcare services into an acute floor model, were not implemented

[§§] Limerick Pathfinder — a service provided collaboratively between the national ambulance service and the occupational therapists and physiotherapists from University Hospital Limerick, operating Monday to Friday (8am-7pm). Pathfinder's 'rapid response team' respond to emergency calls from older people, the person is assessed in their homes by an advanced paramedic and occupational therapist or physiotherapist. The team supports the older person to remain at home, if safe to do so and links them with a wide range of alternative hospital and community services. Pathfinder's 'follow-up team' comprising physiotherapist and occupational therapist provide home-based rehabilitation.

[***] Alternative Pre-hospital Car Pathway (APP Car) — a community emergency medicine collaboration between the national ambulance service and University Hospital Limerick, operating Monday to Friday (10am-8pm). The APP Car team comprises a registrar in emergency medicine from University Hospital Limerick and an emergency medical technician from the national ambulance service. The APP Car team respond to low-acuity emergency calls and provide patient care in the community or refer patients to the appropriate community or specialist service. The team use a national ambulance service vehicle and respond to appropriate calls within a 45-minute radius.

during this inspection. Efficiencies in patient flow were evident during this inspection through the level of compliance with the targeted timelines and KPIs. Specifically:

- there was some improvement in the level of compliance with the 24-hour PETs but further improvement is needed to ensure full compliance with all other PETs (see Table 6)

Table 6: Average PETs compared to HSE Target during HIQA Inspections in 2022, 2023 and 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 2022	50.9%	66.3%	91%	46.8%	76.7%
University Hospital Limerick inspection 2023	54.8%	71.3%	93.1%	48.2%	80.4%
University Hospital Limerick inspection 2025	48%	43%	89%	28%	94%

- there was a 75% compliance rate with the KPI of 15 or less admitted patients located on the emergency department's corridor at 8am
- ALOS was comparable to other Model 4 hospitals
- the number of DTOC was consistently below 10
- the number of DTOC was significantly lower than most other Model 4 hospitals
- performance with ambulance crews' readiness and mobility to receive another emergency call after handover (clinically and physically) in the emergency department had improved, with the turnaround times ranging from 17 minutes to 30 minutes (national target is 20 minutes).

During this inspection, the Emergency Medicine Early Warning System (EMEWS) was being implemented on a phased basis on non-admitted patients receiving emergency care in the emergency department. The EMEWS supported the recognition, timely and appropriate response of any clinical deterioration in all patients triaged as level 2 and 3 (Manchester Triage System) accommodated in zones B and C of the emergency department. Full implementation of the EMEWS for patients in all other areas of the emergency department was expected by July 2025. Relevant observations were taken and recoded on non-admitted patients receiving emergency care in zone A and other areas of the emergency department. The Irish National Early Warning System (INEWS) was completed on all admitted patients in the emergency department. The Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool was used to support the clear and effective exchange of information among staff. Zone A comprised seven treatment areas,

zone B comprised seven treatment areas and zone C comprised five treatment areas. On the morning of this inspection, there was seven patients in zone A (all admitted patients), 15 patients in zone B (11 admitted patients and 4 emergency department patients) and 13 patients in zone C (11 admitted patients and 2 emergency department patients). Nurses were specifically assigned to complete EMEWS on all non-admitted patients receiving emergency care in zones B and C. Nurses were also specifically assigned to complete INEWS on all the admitted patients in all the zones and other areas of the emergency department. Compliance with the early warning system's escalation protocol and ISBAR[3] was audited and a sample of monthly audits reviewed by the inspectors showed good levels of compliance (100%) with both early warning systems in the months prior to this inspection.

Measures had been implemented and were in place to improve the early identification and timely management of sepsis and to highlight sepsis on healthcare records. The sepsis care bundle was used; this along with the 'red folder' service improvement initiative, facilitated the early identification of and timely intervention for patients with suspected or confirmed sepsis. The timely administration of antimicrobials (within one hour of the identification of sepsis) was audited monthly. A sample of audits completed in the months preceding this inspection showed a varied level of compliance with the administration of antimicrobials within one hour of the identification of sepsis (rate 77%-100%). There was a good level of compliance with the administration of antimicrobials within three hours of the identification of sepsis (rate 93%-100%) and five hours of the identification of sepsis (rate 97%-100%). There was a robust process in place to review and examine the cause and impact of any delayed administration of antimicrobials (not administered within one hour) and to improve clinical practice so as to ensure the timeliness of intervention, treatment and management of sepsis. There was evidence that corrective actions were implemented to improve any areas of non-compliance and to support the timely management of patients identified with sepsis.

There was a robust process to ensure the appropriate placement of patients requiring transmission-based precautions. A prioritisation system was in place based on the infection status of each patient. Infection prevention and control nurses visited the emergency department daily to support and advise staff. Terminal cleaning was carried out following any suspected or confirmed cases of communicable infectious diseases.

During the inspection, the emergency department was observed to be clean and well maintained. This was consistent with a sample of environment and patient equipment audits carried out in the months preceding this inspection that showed a good level of compliance with expected hygiene standards (range 92%-100%). Maintaining adequate physical spacing between trolleys placed on the corridors was a challenge, this increased the risk of transmission of infections.

A comprehensive clinical pharmacy service was not available to the emergency department because of staff shortfalls in the pharmacy department. A clinical pharmacist was assigned to the department and medication reconciliation was prioritised for admitted patients. A pharmacy technician replenished and maintained the emergency department's medication stock. Non-stock medications were sourced outside core working hours by the operational

ADON. Administration of medications outside core working hours was sometimes delayed due to a difficulty in accessing some medications. This had the potential to pose a risk to patients, especially those needing time-sensitive medication. An automated system for medication management was procured for the emergency department. With a planned installation date of Q3 of 2025, this system will mitigate this risk when installed. Staff had access to a range of appropriate up-to-date clinical policies, procedures, protocols and guidelines through the hospital's computerised document management system.

The system in place to report, track and manage patient safety incidents and serious reportable events and incidents aligned with national guidance. Serious reportable events and incidents were escalated to and managed by the UEC directorate's SIMT. Complaints about the emergency department were managed in line with national guidance, with oversight by the CNM 3, ADON, UEC directorate's DON and business manager. Complaints were tracked and trended and monitored by the UEC directorate. Learnings from patient safety reviews and complaints was shared at operational meetings and departmental huddles as part of the continual quality improvement process.

Compliance with this national standard improved between March 2022 (non-compliant) and February 2023 (partially compliant), but since then compliance levels have remained the same at partially compliant. There were systems and processes in place to protect patients from the risk of harm. Service improvement initiatives such as the virtual ward had been introduced since the November 2023 inspection. The waiting times for triage and medical assessment had improved and the times recorded during this inspection were commendable, but further improvements are needed in this area. The mismatch between demand and inpatient bed capacity remains, manifesting as overcrowding in the emergency department and in the wider hospital. Controls and actions were applied to mitigate risks to patient safety arising from the mismatch. The inspectors noted the use of surge areas as a risk mitigation measure for the significant attendance and resultant overcrowding in the emergency department, but:

- the risks of placing patients on corridors is not a medium or long-term sustainable solution to deliver safe, quality care when in a continuous state of escalation
- surge capacity will continue to be used until such time as capacity deficits are addressed and the imbalance between demand and capacity in University Hospital Limerick is countered
- EMEWS was not fully implemented in the emergency department
- the timeliness of intervention, treatment and management of sepsis should continue to be an area of focused improvement.

Judgment: Partially compliant

Section B: Further observations and findings from monitoring activity of HSE services in the Mid West

This section is informed by findings from visits to the four acute hospitals — Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital, St John's Hospital Limerick and three rehabilitation and community inpatient healthcare services; St Camillus' Community Hospital, St Josephs' Community Hospital and St Ita's Community Hospital. A one-day announced visit was carried out in each of these services. The purpose was to collect, confirm and validate how the services supported the design and delivery of urgent and emergency healthcare services in the Mid West Region of Ireland. The breakdown of the dates and times of these announced inspections are in Appendix 3.

Medical Assessment Units in HSE Mid West

The MAUs in Nenagh Hospital, Ennis Hospital and St John's Hospital were established as part of the reconfiguration of hospitals under the framework for smaller hospitals.[†††] They were established to support the delivery of care to adult patients suffering from a range of medical conditions who require urgent or emergency care. The three MAUs in HSE Mid West operated seven days a week and the operating hours were standardised — 12 hours (8am to 8pm) Monday to Friday and 10 hours (8am to 6pm) at weekends and bank holidays. Planned capacity (treatment areas) in the three MAUs were similar — Nenagh Hospital comprised seven treatment areas, St John's Hospital comprised seven treatment areas and Ennis Hospital was the largest with 10 treatment areas. All three MAUs functioned effectively and as intended within their current capacity and scope. All MAUs reviewed and treated two to three patients per treatment area each day. Each MAU had a defined inclusion and exclusion criteria based on the medical specialties available in their respective hospital. All three MAUs accepted referrals for adult patients aged 16 years and over. Patients were referred directly from primary care services and from the emergency department in University Hospital Limerick. There was a standardised referral process via a centralised booking system in University Hospital Limerick; from here patients were streamed to each MAU. The national ambulance service also conveyed patients who met the MAU's inclusion criteria. Primary care services, the emergency department and national ambulance service had a dedicated number of appointments or slots in each MAU each day.

There was clear, robust, integrated governance structures that oversaw the delivery of care in the MAUs. The CEO for Mid West Acute and Older Persons Services was the overall accountable person with responsibility and accountability for the quality of healthcare services delivered in the MAUs. The UEC directorate and respective operational management team in each hospital were responsible for the day-to-day operational functioning and had oversight

[†††] Published by the Department of Health and HSE in 2013, the framework for smaller hospitals defined the role of the smaller hospitals and outlined the need for smaller hospitals and larger hospitals to operate as a single (the Hospital Group).

of the quality and safety of care provided in the MAUs. Activity data and performance with quality metrics was reported monthly to the UEC directorate and QualSEC. QualSEC provided the CEO and EMT with assurances about the quality of healthcare services in the MAUs.

Care in the MAUs was delivered by a highly focused and committed multidisciplinary team comprising consultant physicians, NCHDs at registrar and senior house officer grades, CNM 2s, CNM 1s, ANPs, nurses, HCAs and administrative support staff. HSCPs included medical social workers, speech and language therapists, physiotherapists and occupational therapists. Medical and nursing staff resourcing was fairly consistent across all three MAUs, with no reported shortfalls. Shortfalls were reported across all HSCP disciplines in all MAUs.

There was a standardised review and treat pathway in the MAUs. Patients presenting to the units were assessed by an NCHD at registrar grade and or by a consultant physician. Each MAU had a designated lead consultant physician who was jointly appointed by and or had sessional commitments in University Hospital Limerick. The designated lead was responsible for the day-to-day functioning of the unit and was on site daily. There was a robust, formal process in all MAUs to manage and transfer patients whose clinical condition deteriorated. Patients were transferred to the emergency department in University Hospital Limerick. The process was underpinned by a formal policy and staff knew the process.

MAUs in Nenagh Hospital and St John's Hospital reported an increase in new attendances in 2024 compared to 2023 numbers (see Table 7).[‡‡‡] All three MAUs functioned at or above 100% occupancy rate, Monday to Friday. Lower occupancy rates were reported at weekends and during bank holidays; staff mainly attributed this to a decrease in the number of referrals from primary care services. The average time spent in the MAUs ranged from 3 hours 20 minutes (Nenagh Hospital) to 4 hours 33 minutes (St John's Hospital), with the wait for diagnostics reported by staff to be the main contributor to longer waiting times. The rate of same-day discharge varied in the three MAUs — 83.2% (Nenagh Hospital); 82% (Ennis Hospital) and 89% (St John's Hospital).

Table 7: Attendance to MAUs 2024 and variance to 2023

Attendance to MAUs in 2024 and Variance to 2023				
Hospital	Attendance 2024	Average Monthly Attendance	Average Daily Attendance	Variance % when compared to 2023
Nenagh Hospital	4,443	370	12	+6.6%
St John's Hospital	4,237	353	12	+21.7%
Ennis Hospital	7,218	602	20	-2.80%

[‡‡‡] Performance data from January to December 2023 and from January to December 2024 was used to compare year on year performance.

All three MAUs had controlled access to same-day diagnostics (radiology (computed tomography (CT) scans, MRIs, X-rays), ultrasound and laboratory) on-site or off-site. Shortfalls in radiology resourcing restricted access to same-day diagnostics in Nenagh Hospital and Ennis Hospital. Staff in all three MAUs reported access to non-invasive cardiology diagnostics as challenging. St John's Hospital did not have access to on-site laboratory services and used the laboratory services in University Hospital Limerick, with a turnaround time for results of three to four hours. Point-of-care testing was available in Nenagh Hospital, with on-site access to laboratory services restricted after 5pm. Restricted access to diagnostics and laboratory services impacted on the effective and efficient delivery of care and overall occupancy rate in Nenagh Hospital and Ennis Hospital. Urgent and time-critical CT scans, such as CT brain scans, were prioritised for same-day diagnostics. If medically stable, patients awaiting diagnostics were discharged from the MAU, with an appointment given to return for review in the MAU. This process supported patient discharge and follow-up depending on clinical need. Five to 10 patients were reviewed daily in the review clinics in each MAU.

Injury units in HSE Mid West

Injury units were located in Nenagh Hospital, Ennis Hospital and St John's Hospital, treating patients with non-life threatening injuries that were unlikely to require a hospital stay or result in long-term disability. The injury units in HSE Mid West operated seven days a week; operating hours were standardised — 11 or 12 hours (8am to 7pm/8pm), including weekends and bank holidays. Planned capacity (treatment areas) in the three injury units were similar - Nenagh Hospital comprised four treatment areas, Ennis Hospital comprised five treatment areas and St John's Hospital comprised four treatment areas. All three injury units functioned effectively and as intended. All accepted referrals for people over the age of five years with minor injuries such as sprains, breaks and burns. Patients were referred directly from primary care services, the emergency department in University Hospital Limerick or self-referred. Each injury unit had a defined inclusion and exclusion criteria. Clear, robust, integrated governance structures governed the delivery of care in the injury units. All three injury units reported an increase in attendances in 2024 compared to 2023 (see Table 8).

Table 8: Attendance to Injury Units 2024

Attendance to Injury Units in 2024 and Variance to 2023				
Hospital	Attendance 2024	Average Monthly Attendance	Average Daily Attendance	Variance % when compared to 2023
Nenagh Hospital	12,129	1,011	33	+7.9%
St John's Hospital	17,442	1,454	48	+4.4%
Ennis Hospital	16,037	1,336	44	+15%

The average time spent in the injury units ranged from 1 hour (St John's Hospital) to 1 hour 6 minutes (Ennis Hospital). Care in the injury units was delivered by a committed and dedicated multidisciplinary team comprising a consultant in emergency medicine, NCHDs at registrar and senior house officer grades, ANPs, nurses, HCAs and administrative support staff. There was no reported shortfalls in nursing and medical staffing at the time of inspection. Patients presenting to the injury units were triaged, reviewed and assessed by an NCHD at registrar grade and or an ANP.

Each injury unit had a designated lead consultant in emergency medicine, appointed in University Hospital Limerick, with sessional commitments to the injury unit. The designated lead was responsible for the clinical care provided in the unit, was on site weekly and accessible over the telephone when needed. Radiology reports were available to staff via the national integrated medical imaging system. All three injury units had access to same-day diagnostics located on-site. The number of people presenting outside of criteria to the injury units was less than 10%. People presenting outside of scope were directed to primary care services and or University Hospital Limerick's emergency department.

Uptake and utilisation of surge capacity in acute hospitals in HSE Mid West

University Hospital Limerick utilised surge capacity in Nenagh Hospital, Ennis Hospital, St John's Hospital and Croom Orthopaedic Hospital when needed. The escalation process to enact the surge capacity was clear and formalised. Operational managers in the four acute hospitals knew, understood and could describe the process. The pausing of day case and inpatient scheduled care provided 32 surge beds in Nenagh Hospital and Ennis Hospitals, six surge beds in St John's Hospital and 20 surge beds in Croom Orthopaedic Hospital to be used for medical patients. The governance and oversight of the clinical care delivered when using surge capacity was clear and unambiguous, with governance and oversight by the medical directorate.

Seventeen patients that were identified as clinically appropriate to transfer from University Hospital Limerick were transferred daily to Nenagh Hospital, Ennis Hospital, St John's Hospital and Croom Orthopaedic Hospital. The appropriate early warning system was used in all hospitals to recognise clinical deterioration. There was a robust, formalised process in place to transfer patients experiencing clinical deterioration to University Hospital Limerick and staff who spoke with the inspectors could describe the process. Operational managers with responsibility for patient flow from each of the acute hospital sites reported they had a good working relationship with University Hospital Limerick's head of bed management and attended daily operational and patient flow meetings with members of the HSE Mid West acute services EMT.

Nenagh Hospital, Ennis Hospital and Croom Orthopaedic Hospital operated above 90% bed occupancy rate. St John's Hospital operated at 103% bed occupancy rate. Patient's length of stay and the number of delayed discharges were monitored in all acute hospitals and were reported to the HSE and HSE Mid West Acute Services EMT as part of the monthly reporting requirements. Staff from Nenagh Hospital, Ennis Hospital, St John's Hospital and Croom

Orthopaedic Hospital attended and presented at weekly ALOS and DTOC meetings. The ALOS for medical patients in Nenagh Hospital and Ennis Hospital was aligned with the national target (≤7.0 days). The ALOS for medical patients in St John's Hospital was higher (11.8 days) than the national target. St John's Hospital's executive management team and clinical director were aware of this and committed to reviewing the contributing factors and making improvements to bring the hospital into alignment with the national target. The ALOS for emergency surgery in Croom Orthopaedic Hospital was higher (eight days) than the national target (≤6.0 days). The number of DTOCs were small in Nenagh Hospital, St John's Hospital and Croom Orthopaedic Hospital (range four-six cases). Ennis Hospital had the highest number of DTOC at 14. This high rate of DTOC was attributed to individual patients' complex needs, access to and availability of community nursing homes and home care packages. The five acute hospitals in HSE Mid West had access to HSE-governed post-acute inpatient rehabilitation services, convalescence and or transitional care beds in community hospitals and private providers — St Patrick's Hospital, Cashel; Community Hospital of the Assumption, Thurles; Cahercalla Community Care (25 beds) and Bartra Healthcare (50 beds).

Post-acute inpatient rehabilitation services in HSE Mid West

HSE-governed post-acute inpatient rehabilitation services were available in the three community hospitals in HSE Mid West — St Camillus' Community Hospital (33 beds), St Ita's Community Hospital (28 beds) and St Josephs' Community Hospital (12 beds). In addition, the HSE had procured 50 inpatient rehabilitation beds in Nenagh Transitional Unit, which was operated by Bartra Healthcare. There was a reported limited availability in post-acute inpatient rehabilitation beds that contributed to delayed transfers of care in University Hospital Limerick.

Bed availability and utilisation of post-acute inpatient rehabilitation services was dependent on nursing staff resources. All available inpatient rehabilitation beds were utilised during this inspection. The services had defined, formal reporting and accountability arrangements. The operational manager in each service reported to the General Manager of Older Persons Services, who reported upwards to the head of services for older persons services and who in turn reported to the CEO for Mid West Acute and Older Persons Services. The single governance approach for acute and community services enabled through the revised reporting arrangements to the CEO for Mid West Acute and Older Persons Services facilitated and supported better integration of acute and community services. The majority of post-acute inpatient rehabilitation services provided mixed rehabilitation (trauma and orthopaedic, brain injury, stroke, spinal cord injury, neurology) and specialist gerontology rehabilitation services. Capability to meet the rehabilitation needs of patients was dependent on the availability of nursing and HSCP workforce, access to essential services and rehabilitation interventions. Patients' individual rehabilitation needs ranged from low to highly complex based on their clinical condition and their initial needs assessment.

The post-acute inpatient rehabilitation services had a consultant-led clinical governance structure with a consultant geriatrician and or consultant in rehabilitation medicine as the

designated clinical lead. Some consultants were jointly appointed with University Hospital Limerick. All consultants were on site in the rehabilitation services for a specific number of days each week during core working hours. Consultants were supported by NCHDs at registrar and senior house officer grade. NCHDs were on-site during core working hours in St Camillus' Community Hospital and St Ita's Community Hospital. An NCHD at registrar grade was on site in St Josephs' Community Hospital three days a week. The registrar in St Josephs' Community Hospital rotated from ICPOP on a three-monthly basis. Outside core working hours, at weekends and bank holidays, medical cover was provided by an NCHD at senior house officer grade. There was a robust, formalised process in all post-acute inpatient rehabilitation services to transfer patients whose clinical condition deteriorated to University Hospital Limerick's emergency department. The process was underpinned by a formal policy and staff who spoke with the inspectors could describe the process.

All post-acute inpatient rehabilitation services had a consultant-led admission process, underpinned by a formal policy and the process was standardised across all services. All services had clear, documented admission criteria and referral pathways. Patients requiring rehabilitative care were referred from the acute services and other community services via an electronic referral system (ePMS). University Hospital Limerick was the main referral source, with a small number of patients referred from other acute services and community services. The consultant lead and CNS for each service reviewed all referred patients and where appropriate, carried out a comprehensive geriatric assessment using a validated tool to determine the patient's suitability for rehabilitation care, their individual rehabilitation needs and goals.

Significant variance in nursing and HSCP staffing levels was evident across all post-acute inpatient rehabilitation services. Substantial shortfalls in physiotherapists, speech and language therapists, occupational therapists, psychologists and medical social workers were reported in all services. The shortfalls in HSCPs impacted on the level of therapies and medical social worker supports available to patients. All services reported shortfalls in nursing staff, with a substantial difference in the shortfalls reported, ranging from 2.38 WTE (St Ita's Community Hospital) to 8 WTE (St Camillus' Community Hospital). The availability of inpatient rehabilitation beds was impacted by nurse staffing shortfalls; with 20 (61%) of the 33 rehabilitation beds in St Camillus' Community Hospital operational during this inspection, 39% of the hospital's rehabilitation beds were not used. There was a plan in place to increase nursing staff numbers in St Camillus' Community Hospital. National and international recruitment campaigns were ongoing at the time of inspection. It was reported to the inspectors that St Camillus' Community Hospital would have its full complement of nursing staff for the rehabilitation units in April 2025.

The post-acute inpatient rehabilitation services did not have a defined and standardised set of national metrics to measure and benchmark the services against. All services monitored patient's length of stay and DTOC. Patient's length of stay varied, it was individual to each patient and dependent on them achieving their rehabilitation goals. Discharge destinations were monitored by all services, with the majority of patients transferred home. All services

collected data on service activity and clinical outcomes, with improvement in mobility, cognition, communication and quality of life the most common clinical outcome monitored.

Conclusion

Since March 2022, findings from HIQA's monitoring activity in University Hospital Limerick's emergency department has demonstrated a steady and incremental improvement in the level of compliance with the national standards focusing on leadership, governance and management (standard 5.5), workforce (standard 6.1) and safe care and support (standard 3.1). Measures have been implemented to support patients attending for care in the emergency department, but nonetheless compliance with the national standard from the theme of person-centred care and support (standards 1.6) was judged to be non-compliant throughout HIQA's monitoring activity over the past three years (see Appendix 1 and 2).

During this inspection, areas of progress in working to meet the requirements of the four national standards monitored were identified. There was evidence of operational efficacies and process improvements to support the delivery of quality, urgent and emergency healthcare services across HSE Mid West. The corporate and clinical governance arrangements in the hospital and across the Mid West Region were reconfigured to align with the HSE's health region structures. There was a comprehensive, collaborative and integrated whole system, regional approach to the delivery of urgent and emergency healthcare services. There was a clear plan to effectively manage the demand for urgent and emergency healthcare services in University Hospital Limerick, improve operational efficiencies, increase surge capacity and ensure efficient patient flow throughout HSE Mid West. The modified EMT had good operational grip and there was robust governance and oversight of the quality and operational delivery of urgent and emergency healthcare services 24/7. Decision-making, responsibility and accountability for the delivery and quality of urgent and emergency healthcare services was devolved to appropriate persons in executive and operational managerial roles, who were accountable and regularly reported to the CEO.

Since March 2022, there has been a substantial uplift in staffing levels across all professions, disciplines and grades in University Hospital Limerick. This has resulted in changes in work practices that have further supported the efficient delivery of urgent and emergency care in University Hospital Limerick. National and international staff recruitment campaigns were in progress at the time of this inspection and it was reported that these campaigns were successful in filling approved nursing and medical positions, including those aligned with the new 96-bed block coming online in the hospital in Q3 of 2025. Progressing the implementation of phase two of the safe staffing framework will further support and ensure sufficient nursing and HCA staffing levels and skill mix in the emergency department.

The operational and process improvements at University Hospital Limerick and HSE Mid West have resulted in better compliance with quality metrics, especially the 24-hour PETs, but further improvement is needed to achieve full compliance with these metrics. The substantive issue of capacity constraint continues, as manifested in the hospital's constant state of escalation, use of surge capacity, admitted patients in the emergency department and the number of patients receiving care on trolleys in inpatient areas. Furthermore, the inequity between scheduled and unscheduled care delivery, generated from the measures introduced

to manage the demand for urgent and emergency care, may have significant and wide-ranging effects for patients awaiting scheduled care. The revised and enhanced management arrangements were working as effectively as might reasonably be expected within the current context of the mismatch between demand and capacity to address any potential and actual risks to patient safety.

Other services were effective in supporting the delivery of urgent and emergency healthcare services in HSE Mid West and emergency department non-conveyance. The MAUs and injury units provided appropriate care and treatment for people with low-acuity illness and or injury. All MAUs and injury units operated effectively, within scope and at full capacity. They supported the reduction of low-acuity, non-urgent presentations to University Hospital Limerick's emergency department. Reported shortfalls in radiology resourcing limited full access to diagnostics in Nenagh Hospital and Ennis Hospital, which impacted the efficiency of care and potentially affected overall occupancy rates in the MAUs in those hospitals. Adequate access to same-day diagnostics would support the timely assessment, treatment and discharge of patients from the MAUs. All available post-acute inpatient rehabilitation beds were fully utilised during this inspection. All available surge beds in HSE Mid West were used during escalation to support efficient patient flow in University Hospital Limerick. Bed availability in the post-acute inpatient rehabilitation services was dependent on staff resourcing, with one service (St Camillus' Community Hospital) particularly challenged. Substantial shortfalls in HSCP staff resources in the community health services visited impacted on availability of therapies and medical social worker supports for patients using post-acute inpatient rehabilitation services. Adequate resourcing of multidisciplinary teams will further strengthen care delivery in these services.

Hospital admission avoidance pathways supported people with low acuity to be managed and treated in their own homes or in the community in line with Sláintecare. They were also effective in supporting emergency department non-conveyance and in reducing the numbers of low-acuity, non-urgent presentations to University Hospital Limerick's emergency department. Focused investment will increase the bed capacity in University Hospital Limerick and across HSE Mid West. It is likely that any gain from the 96-bed block due to open in Q3 of this year will be modest given the continuing significant number of attendances at University Hospital Limerick's emergency department. Additionally, at the time of writing this report, the contract for utilisation of 50 post-acute rehabilitation beds in Nenagh Transitional Care Unit to support the HSE was due to expire in September 2025. This may impact the overall net gain of the new 96-bed build. In the longer term, the 196 new beds that have already been committed to under the A*cute Hospital In-patient Bed Capacity Expansion Plan 2024-2031* will also increase capacity across HSE Mid West. Additional bed capacity will also be achieved with the decanting of appropriate surgical care to the off-site surgical hub when it opens in 2026, with the building and opening of a further on-site 96-bed block in 2029 and with the new private hospital due to open in Limerick in Q4 of 2025.

As the findings in this report demonstrate, operational efficiencies and process improvements have occurred over the last three years in University Hospital Limerick, but further

improvement is needed in the medium and long-term to address the mismatch between demand and capacity and for University Hospital Limerick to function more efficiently as a tertiary referral centre providing complex specialist healthcare services for the growing and diverse, multidimensional population of the Mid West Region of Ireland. HIQA will continue to monitor the progress in implementing actions being employed to bring the hospital into full compliance with the national standards monitored during inspection (see Appendix 4).

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 four national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the on-site 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 standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital 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 hospital's 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.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
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
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
Quality and Safety Dimension	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-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.	Partially compliant

Appendix 2 – Judgment of Compliance with *National Standards for Safer Better Healthcare* 2022, 2023 and 2025

National Standard	Judgment			
	March 2022	February 2023	November 2023	January 2025
Capacity and Capability Dimension				
Theme 5: Leadership, Governance and Management				
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant	Partially compliant	Substantially compliant	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.	Non-compliant	Partially compliant	Substantially compliant	Substantially compliant
Quality and Safety Dimension				
Theme 1: Person-centred Care and Support				
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant	Non-compliant	Non-compliant	Non-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.	Non-compliant	Partially compliant	Partially compliant	Partially compliant

Appendix 3 – The on-site inspections or site visits of University Hospital Limerick and relevant HSE Mid West health services were carried out during the following dates and times

Hospital	Date	Times of Inspection	Inspector	Role
University Hospital Limerick	30 January 2025	09.00 – 21.00hrs	Denise Lawler	Lead
			Geraldine Ryan	Support
			John Tuffy	Support
			Emma Cooke	Support
			Eileen O' Toole	Support

Hospital	Date	Times of Inspection	Inspector	Role
Nenagh Hospital	11 February 2025	09.00 – 15.15hrs	Elaine Egan	Lead
			Geraldine Ryan	Support
Ennis Hospital	12 February 2025	09.00 – 16.15hrs	Geraldine Ryan	Lead
			Elaine Egan	Support
St John's Hospital, Limerick	12 February 2025	09.00 – 15.15hrs	Eileen O' Toole	Lead
			Denise Lawler	Support
Croom Orthopaedic Hospital	12 February 2025	09.00 – 15.50hrs	Aedeen Burns	Lead
			Emma Cooke	Support
St Camillus' Community Hospital	18 February 2025	09.00 – 14.15hrs	Eileen O' Toole	Lead
			Denise Lawler	Support
St Joseph's Community Hospital	18 February 2025	09.00 – 15.15hrs	Geraldine Ryan	Lead
			Elaine Egan	Support
			Angela Moynihan	Support
St Ita's Community Hospital	19 February 2025	09.00 – 15.30hrs	Aedeen Burns	Lead
			Emma Cooke	Support

Appendix 4 – Compliance

Compliance Plan

Service Provider's Response

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with the national standard.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard.

Measures already implemented in 2025

- Comfort packs are provided to patients which include eye mask /sleep mask, foam ear plugs. Toiletry packs are also available.
- An emergency clothing stock has been introduced to the Emergency Department which provide clothing to patients, who find themselves in the department without essentials from home.
- Specific additional rounding is taking place by HCA's ensuring patient have pillows/blankets.
- PALS Managers complete regular rounds within the department to support patients in the Department. They offer comfort packs, pillows, clinical care updates if required. They offer to contact family/N.O.K. if a patient requires same. They offer support and give the contact details for the PALS service if required. They offer to address any immediate concerns the patient has and make every effort to resolve them quickly and effectively.
- To promote dignity and privacy of patients, a cubicle is protected for use by the clinical teams when carrying out intimate clinical care within the zones in the ED.
- Portable screens are routinely available for use to enable privacy and dignity.
- Patients who are identified for 'End of Life Care' are prioritised for a bed on the ward, if one is not available, the patient is accommodated in a single cubicle in the Clinical Decision Unit.
- Patients who present to the ED who are part of the Haematology/Oncology service are prioritised for isolation if required and are transferred to the 2 assessment cubicles in Haematology/Oncology Ward for work up (if Resuscitation is not required).
- The ED floor plan in line with the fire plan for the ED, is being implemented which maximises available space and promotes physical distancing between trolleys.

- Escalation plan has been further reviewed/ updated to reflect the current practice of flowing patients on trolleys to ward trolley spaces from ED to mitigate overcrowding in ED with a cap of 15 patients on trolleys on corridors set now being introduced (April).
- There has been a significant increase in staffing levels across all grades of staff within the ED to ensure that all those patients who are awaiting a bed have their care needs met.
- Patients are moved to the wards on trolleys to ensure that overcrowding in the ED is minimised as far as possible in line with nationally agreed Escalation Framework.
- Information boards have been installed in all the Zones within the Emergency Department to ensure that patients and their loved ones understand the operations of the department.
- A specific patient experience committee has been established within the emergency department including a patient representative to drive improvements.
- Executive management team on site, who convene an Operational site meeting at 08.45 am Monday - Friday with Executive on call convening same meeting at the weekend. This meeting reviews previous day's performance, real time data and agrees corrective measures and plan for the day.
- KPI 0 patient > 75years of age awaiting admission breaches the 24hr PET at 08.00am in place and now routinely achieved - Monitored daily by Executive.
- Integrated DTOC meeting established, which meets weekly to ensure delayed transfers of care are minimised. DTOC: UHL < 10 average secured and maintained.
- Several acute pathways are in place that enable the successful streaming of patients from the ED

    - Acute Medical Assessment unit pathway
    - Acute Surgical Assessment unit pathway
    - GEMS unit for >75yr old pathway
    - STEMI pathway
    - Direct Model 2 site transfers pathway
    - Clinical Decision Unit pathway
    - Stroke
    - Fractured Neck of Femur / Hip fracture.

- Wards identified as having insufficient shower facilities for patients on trolleys accommodated on wards all have appropriate ablution facilities.

Measures still for implementation in 2025:

- Procurement and installation of personal 'safes' for patients accommodated on trolleys - June 2025 – to be located on trolley.
- 16 bed ward (acute) - date for physical handover May 2025.
- 96 bed construct (acute) - date for physical handover September 2025.
- > 100 bed private hospital scheduled for opening during the last quarter of 2025.

Impact

Bed additionality will further reduce reliance on patients being accommodated on trolleys thereby improving necessary patient privacy and dignity.

Measures for introduction > 2025

- 96 bed construct (acute) - date for physical handover 2027.
- Development of a Surgical Treatment Hub not on the UHL campus - date for physical handover 2027.
- As identified in Acute Hospital / In-patient Bed Capacity Expansion Plan 2024-2031 additional new beds for St. John's Hospital (42) Ennis Hospital (48) and Nenagh Hospital (24).

Impact

Bed additionality / treatment site alternative will further significantly reduce reliance on patients being accommodated on trolleys and also enable an increase in elective treatments being undertaken within the region. This again further improving patient dignity and privacy.

Timescale: as indicated above

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.	Partially compliant

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with the national standard.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard.

Measures already implemented in 2025

- Continuous flow of trolleys to ward trolley spaces to reduce the overcrowding and enable the ED to work more efficiently.
- 'Bed meetings' held three times a day to focus on status of the site, long PETS with specific focus on long waits across the acute floor.
- Improved pathways for frail elderly through greater use/ referral to the Geriatric Emergency Medicine Unit (GEM Unit) which is operational 24/7, seven days a week**.**
- Increased senior decision maker presence (rostered) in the ED over the weekend and across the hospital site particularly in regard to acute medicine patient cohort.
- Continue to maximise the number of inter hospital direct transfers from the ED to Level 2 Hospitals thereby creating capacity.
- All clinical staff within the ED have completed EMEWS training.
- Safety huddle in operation within the ED.
- ED Consultant in Triage.
- The Phase 2 SAFER staffing nursing levels for the management of unscheduled care has been implemented.
- Additional staff have been allocated to triage and triage times are being monitored closely across the 24-hour period within ED and by the Executive. – adult pilot is demonstrating improvements.
- Virtual ward initiative established with an occupancy target of 25 patients set for each day. Performance monitored daily.

Measures still for implementation in 2025:

- To complete the roll out of EMEWS to all Zones in the ED - completion July 2025.
- To complete the zoning plan within nursing in the ED - completion July 2025.
- To focus on further improving the triage times to ensure compliance with the triage time recommend by the HSE's national emergency medicine programme**.** Pilot currently demonstrating improvements **-** completion Q4 2025.

- To complete the installation of the automated medication management system which has been procured - completion Q4 2025.
- The Phase 1 SAFER staffing nursing levels for the management of patients awaiting admission - awaiting HSE confirmation.

Impact

Achievement of Compliance.

Timescale: as indicated above