

Welcome

Welcome to the latest issue of HIQA News.

Since our last issue, we have engaged extensively with our stakeholders in the health and social care sector with the goal of making services safer and promoting a greater culture of respect for people using services. This edition reports on a number of developments to this end.

Our Healthcare team is embarking on a review of nutrition and hydration care in the country's acute hospitals. It is also examining how hospitals use antibiotics, with a view to reducing Healthcare Associated Infections, and it has issued guidance on lessons from previous HIQA investigations and reviews.

We continue to promote service improvements in nursing homes, residential services for people with disabilities, and children's residential services, and to work with staff to achieve this. We also hope you can help us determine, as part of a public consultation, our priorities for our next corporate plan.

Our Health Technology Assessment (HTA) team has just published recommendations on screening for a common abnormal heart rhythm called atrial fibrillation, and we will shortly be consulting with the public on a draft HTA on changes to the BCG vaccination programme for the prevention of TB in Ireland.

We are delighted to announce the appointment of Rachel Flynn as Director of Health Information. Rachel comes with significant experience in the field of health informatics and has worked very effectively as a leader in this field.



Rachel Flynn, HIQA's newly appointed Director of Health Information

In related developments, new standards for the individual health identifiers have also been published, while work continues on developing recommendations for patient-safety surveillance systems for Ireland.

Meanwhile, some residential centres for people with disabilities have in recent times been the focus of much public concern. Nonetheless, many centres are adapting well to the new regulatory environment and are complying with the requirements of the regulations and [National Standards](#).

This is a welcome development. However, in many centres, we continue to see failures to safeguard residents, poor standards of care, and poor oversight and governance. All of these deficiencies erode the rights, respect and dignity of people living in these centres.

While we recently took the unprecedented action of cancelling a provider's registration due to significant issues seen in a Co Kilkenny centre, we will continue to prioritise our engagement with poorly performing services to ensure that residents and their families are provided with the quality of service that they are entitled to.

Finally, a Memorandum of Understanding (MoU) has been signed between HIQA and the Office of the Ombudsman. The MoU will facilitate the exchange of information and complaints between both organisations in the best interests of the public and the health and social care services.

Until the next time, very best wishes to all.

Phelim Quinn, Chief Executive



Our Chief Executive Phelim Quinn

Public consultation on a BCG vaccination programme review

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The BCG (Bacille Calmette Guerin) vaccine has been routinely given to children in Ireland since the 1950s to reduce the risk of contracting tuberculosis (TB). Ireland and Portugal are the only countries in Europe that continue to vaccinate all newborns, despite neither country being considered to have a high incidence of TB. The most common approach in European countries is to only vaccinate children considered at high-risk of exposure to TB, such as children with parents from a country with a high incidence of TB.

Our Director of Health Technology Assessment and Acting Deputy CEO, Dr Máirín Ryan, comments: "This draft report examines the implications of ending the current policy of universal vaccination and moving to a policy of only vaccinating infants considered to be at increased risk of TB. Risk status is likely to be based on a variety of criteria, including the country of birth of the infant's parents."



Dr Máirín Ryan, HIQA's Director of Health Technology Assessment and Acting Deputy CEO

The public consultation will give stakeholders and members of the public an opportunity to comment and provide feedback on the content of the report, before it is finalised.

HIQA and Ombudsman agreement will benefit the public and health services

On 2 July 2015, our Chief Executive Phelim Quinn and Ombudsman Peter Tyndall signed a [Memorandum of Understanding \(MoU\)](#) on behalf of the Health Information and Quality Authority and the Office of the Ombudsman.



Ombudsman Peter Tyndall and our Chief Executive Phelim Quinn at the signing of the Memorandum of Understanding.

On 2 July 2015, our Chief Executive Phelim Quinn and Ombudsman Peter Tyndall signed a [Memorandum of Understanding \(MoU\)](#) on behalf of the Health Information and Quality Authority and the Office of the Ombudsman.

The MoU will facilitate the exchange of information and complaints between both Offices in the best interests of the public and the health and social care services. The agreement will also establish procedures to assist members of the public in accessing the services of both organisations.

Speaking at the signing, Ombudsman Peter Tyndall said: “The complaints landscape in Ireland, particularly in the health and social care sector, is fractured and complex. There is an onus on regulatory and complaints-handling bodies to ensure that complaints or information received from the public is channelled to the appropriate office. This ensures that anyone with concerns about the service they have received can have those concerns addressed properly, thoroughly and promptly. My Office and HIQA have separate but complementary roles in the health and social care area and on occasion complaints or information received by either office can be of use and benefit to both our offices. This MoU is particularly timely from my Office’s perspective as I will shortly be given jurisdiction over private nursing homes.”

Our Chief Executive Phelim Quinn said: “As we have seen from recent investigations, actively seeking feedback from service users and their families is key to patient quality and safety in the Irish healthcare setting. Without listening to service users there is no opportunity for those working in healthcare to learn and improve the quality and efficiency of services. Efficient, reliable and safe patient care is one of the benefits of listening to and learning from the experiences of service users.

“Although our remit prevents the Authority from investigating individual complaints, we use the information provided to inform our monitoring activity of the centres involved. This information is passed to the provider of the service to investigate. This MoU with the Ombudsman will enable appropriate and effective sharing of information on complaints and concerns about services.”

The full text of the MoU is available on the websites of both offices: www.ombudsman.gov.ie and www.hiqa.ie.

Residential centres for people with disabilities

We continue to check standards of care in residential centres for people with disabilities to ensure the rights of people with disabilities living in these centres are respected, protected and promoted.

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At this point in the year, our inspectors are finding that many providers are adapting well to the new regulatory environment and are complying with the requirements of the regulations and [National Standards](#).

The number of actions required to address areas of non-compliance has decreased significantly in many centres. In recent times, there has been an increase in the number of inspection reports that do not require any actions, indicating substantial compliance with the legal requirements.

Finbarr Colfer, our National Head of Programme: Disability, commented: "In addition, inspectors have come across examples of good practices in many centres, and in some centres examples of innovative responses by providers to residents with very complex needs, responses which respect the rights and individuality of the residents.

"However, in a significant number of residential centres for people with disabilities, inspectors are continuing to find that providers are failing to ensure adequate safeguarding arrangements for residents. Inspectors have found poor standards of care and support, with poor oversight and governance of the delivery of care in these centres."

Finbarr added that these poor practices were having a significant impact on the safety and quality of life for residents.

He continued: "HIQA is committed to bringing about change for residents in these centres, and where that change is not forthcoming in a timely manner, we are committed to taking action against those providers, up to and including cancellation of registration. To this end, HIQA has recently taken the unprecedented action of cancelling a provider's registration of a designated centre for people with disabilities due to significant issues relating to the health and wellbeing of residents."

We will continue to prioritise our engagement with these poorly performing services to ensure that residents are provided with the quality of service that they are entitled to. We will also continue with our registration programme for all such designated centres.

Development of 2016–2018 Corporate plan

We are in the process of developing a new corporate plan to provide strategic direction for the Authority for the 2016–2018 period.

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Our new corporate plan will be a significant document, and will direct our overall work, how we are going to achieve it and set out our vision and principles.



A draft corporate plan will be presented for public consultation in the coming months.

We encourage feedback and ask you to play a part in defining our strategic direction. If you have any questions or require further information, please contact us at corporateplan@hiqa.ie.

New information governance standards for health identifiers

We recently launched the [Information Governance and Management Standards for the Health Identifiers Operator](#), for the introduction of individual health identifiers in Ireland.

We recently launched the [Information Governance and Management Standards for the Health Identifiers Operator](#), for the introduction of individual health identifiers in Ireland.

An individual health identifier is a unique, non-transferable number assigned to all people using health and social care services in Ireland, which will last for their lifetime. Its role is to accurately identify the person, thereby enabling health and social care to be delivered to the right patient in the right place and time.

Based on international best practice, we developed these Standards and consulted with the public about them. The feedback from the public consultation was extremely positive and highlighted the need for information governance and management of the identifiers. The final Standards were approved by the Board of the Authority in July and submitted for approval to the Minister for Health, Leo Varadkar. The Standards were also issued to the Chief Information Officer of the Health Service Executive (HSE), Richard Corbridge.

The Minister commented: “The individual health identifier will be a major step forward in modernising our health service. It will allow us to follow patients and staff as they move through the health service in a way we currently can’t. This will improve patient safety, reduce duplication and errors, and give us a huge amount of new data that we can use to make services more efficient and improve planning.”

HIQA’s Director of Health Information Rachel Flynn said: “Being able to uniquely identify each user will improve patient safety by reducing the number of adverse events that may happen, such as giving the patient incorrect medication or vaccinations, or admitting an incorrect patient for surgery. The individual health identifier is different from an electronic health record, which is an electronic version of people’s medical history.”

A business unit within the HSE will be set up to manage the health identifier record. This business unit will be known as the ‘health identifiers operator’. The HSE has already begun to build the necessary infrastructure to implement the health identifier in Ireland and is currently conducting a privacy impact assessment to ensure privacy risks are addressed.

There will also be a health services provider identifier which will uniquely identify practitioners and organisations who deliver healthcare services.

Rachel Flynn continued: “Individual health identifiers are the cornerstone of eHealth systems and are key for implementing electronic health records and eHealth solutions such as ePrescribing. These electronic systems will greatly improve patient safety. HIQA has developed these Standards to support the introduction of health identifiers into the Irish healthcare system by providing Standards that the health identifiers operator must put into practice.”

Richard Corbridge, the HSE’s Chief Information Officer, said: “The HSE has built the infrastructure required to deliver the individual health identifiers at a national level; this can be made live once the final elements of legislation are formalised and a privacy impact assessment is published. Creating the individual health identifiers is the very first step to truly bringing about benefit to clinical practice through access to information.”

The HSE will trial the use of the health identifier in clinical information systems in the epilepsy electronic patient record, a general practice involving multiple general practitioners (GPs) and the electronic medical record within a hospice. Rachel Flynn concluded: “Implementation of these Standards will promote trust among the public that the registers are established in line with the law and that the personal information associated with each identifier is properly protected.”

Reports on compliance with the Standards will be published on www.hiqa.ie.

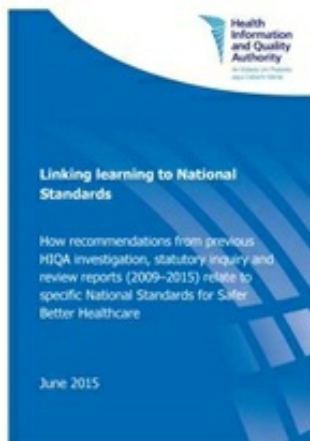
We have also published a [frequently asked questions document](#) and the [Statement of Outcomes](#) from the public consultation on the development of the Standards.



Rachel Flynn, our Director of Health Information

HIQA publishes guide to linking learning to National Standards

We have published [new guidance to help hospitals and healthcare providers improve quality and safety](#) by linking recommendations — from previous HIQA investigations and reviews into healthcare services — with the [National Standards for Safer Better Healthcare](#) that they are expected to meet.



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We have in recent years, as part of our work as a regulator, produced a large amount of corrective actions for public healthcare services in Ireland. [Linking learning to National Standards](#) connects National Standards to real-world care delivery by matching recommendations to identified standards.

We took seven reports that we have published into the quality and safety of healthcare services between 2009 and 2015 and connected each of the 232 recommendations in these reports with an overarching National Standard from our [National Standards for Safer Better Healthcare](#).

Mary Dunnion, our Acting Director of Regulation, explained: “The objective is to show healthcare providers real examples of how particular standards can be met. While risk cannot be eliminated entirely, people responsible for planning, resourcing, managing and delivering healthcare have a duty to protect patients and service users as far as reasonably practicable from the risk of harm. This includes taking measures to avoid any unnecessary risk and creating a culture of learning from patient-safety incidents.

“Findings and recommendations of HIQA investigations and reviews are intended to be used by all healthcare services to inform and improve practice. We identified 32 out of the 45 National Standards in our various recommendations. We found recommendations are repeatedly associated with the same National Standards, mainly in the areas of Effective Care and Support; Leadership, Governance and Management; and Workforce. When reviewing these in their totality, a number of common issues emerge in relation to services provided in public acute hospitals. These issues require uniform implementation across the system.”

High-quality, safe and reliable healthcare is delivered through services that are well defined and communicated, and which are supported by good governance. Delivering care should be based on best available evidence, and performance should be monitored continuously to check if a service meets National Standards. When things go wrong, or desired outcomes are not achieved, there needs to be systems in place to collect, analyse, investigate and learn so that care is improved and mistakes are not repeated.

Mary Dunnion continued: “Hospitals and other services are obliged to review recommendations made in regulatory reports, and see if they are relevant to them. A key factor in this process involves service providers assessing their service against not only the relevant recommendation but also the related overarching National Standard or Standards. The Linking Learning document aims to distil the knowledge we have gained from our previous work in investigating sentinel examples of where services could have been better for patients, and ground them in the National Standards.

“In doing so, our Linking Learning document aims to propel broader learning across the health system, and help services to better ensure that they meet required standards of care and reduce the likelihood of similar adverse patient-incidents occurring again. It is important to explain that we have reduced the number of recommendations in our investigation and review reports. This is in order to place a stronger focus on the important issues that arise from findings and to help services to concentrate on implementing critically important recommendations that would lead to improved safety and quality of care for patients.”



Our Acting Director of Regulation, Mary Dunnion

[Linking learning to National Standards: How recommendations from previous HIQA investigation, statutory inquiry and review reports \(2009–2015\) relate to specific National Standards for Safer Better Healthcare](#)

Guidance on budget impact analysis of health technologies

We have published [Guidance on Budget Impact Analysis of Health Technologies in Ireland](#).

We have published [Guidance on Budget Impact Analysis of Health Technologies in Ireland](#).

Dr Máirín Ryan, our Director of Health Technology Assessment and Acting Deputy CEO, said that in order to ensure consistency in the health technology assessments (HTAs) we and others undertake, we continue to develop guidelines on the conduct of such assessments in Ireland.

Our guidelines provide an overview of the principles and methods that are used in assessing health technologies. They are intended to be a guide for all those who are involved in the conduct or use of HTA in Ireland, promoting the production of assessments that are timely, reliable, consistent and relevant to the needs of decision makers and key stakeholders in Ireland.

Dr Ryan continued: “This document is designed to provide more detailed advice and examples to aid and support clinical guideline developers as well as other practitioners within the Health Service Executive (HSE) tasked with conducting a budget impact analysis.

“It is also intended to inform technology assessments conducted by, or on behalf of the Health Information and Quality Authority, the National Centre for Pharmacoeconomics, the Department of Health and the HSE, to include health technology suppliers preparing applications for reimbursement.”

This guidance document, part of the [series of guidelines](#), has been developed in consultation with the HTA Scientific Advisory Group of the Authority. Providing broad representation from interested and informed parties in healthcare in Ireland, this group includes methodological experts from the field of HTA.

Planning under way on nutrition and hydration inspections

Our Healthcare team is preparing for inspections of nutrition and hydration care in public acute hospitals, and hospitals have submitted self-assessment questionnaires to us as part of the initiative.

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We recently published a [guide to the Authority's review of nutrition and hydration in public acute hospitals](#), and it is expected that unannounced inspections will start in the near future.

Our Acting Director of Regulation Mary Dunnion said: “This review of nutrition and hydration care in acute public hospitals is part of our evolving approach in monitoring healthcare providers' compliance with the [National Standards for Safer Better Healthcare](#) published in 2012. The review will use self-assessment as well as unannounced inspections of a number of care environments.



Our Acting Director of Regulation, Mary Dunnion

“The aim of this new HIQA programme is to assess if hospitals have the essential elements of good nutrition and hydration care in place with a particular focus on nutrition screening and assessment. Our inspection teams will visit hospital wards during mealtimes to see first-hand if patients get good quality meals, receive a choice of food and that they are helped with eating when this is necessary. Inspectors will meet with patients and staff and explore these arrangements, and listen to what patients have to say about their experience.”

All public acute hospitals in the country, other than stand-alone maternity and paediatric hospitals, are included in this programme. We will carry out unannounced inspections in approximately 13 hospitals to gain a patient-focused understanding of how nutrition and hydration care in a given hospital is delivered and how this is experienced by patients at any given time.

Our [new guide](#) for hospitals outlines the procedure for the inspections and how we expect hospitals to respond to findings on nutrition and hydration care. We want to encourage hospitals to adopt and implement evidence-based best practice in nutrition and hydration care and we believe the programme will promote a process of continuous improvement. A national overview of our findings will be published in 2016.

Focus on nursing home inspections

All nursing homes in Ireland are subject to ongoing monitoring and inspection by the Authority.

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We use the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 when conducting inspections and monitoring of nursing homes.



Since 2009, HIQA has been responsible for regulating the quality and safety of services provided in designated centres for older persons in Ireland. Providers are legally responsible for ensuring the safety of residents and for ensuring a good quality service. HIQA provides an external assessment of whether the provider is meeting their legal requirements to protect residents and provide them with a good quality of care.

John Farrelly, our Head of Older Persons' Programme, commented: "A core aspect of this is to consider what life is like for residents living in designated centres, and we seek the views of residents and consider how the delivery of services to residents ensures that they have a good quality of life. We do this through monitoring and inspection of centres and through the registration of centres. We publish our inspection findings on our website."

In 2014, 58% of nursing home inspections nationwide were unannounced and 42% were announced. Our approach ensures that any provider who is persistently non-compliant with the National Standards and regulations, and who place residents at risk of harm, are identified quickly and face proportionate and meaningful enforcement action. We recently published an overview of regulation of nursing homes in 2014 which can be read [here](#).

Nursing home registration renewals

Every three years, nursing homes are required to apply to renew their registration with HIQA in order to carry on operating as nursing homes.

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John Farrelly, our Head of Older Persons' Programme, commented: "This is public confirmation that the provider and people participating in management are fit people to operate a nursing home and that the governance and care is in substantial compliance with the regulations and standards, therefore leading to better standards of care for our most dependent older people."

At this stage in the registration cycle, most centres have had their registration renewed and the final proposals to register are being completed. John continued: "This is the second cycle of registration of designated centres for older people and the Authority is only renewing for the bed numbers applied for if the centre is in full compliance with the physical environment requirements of the regulations."

We have also published [our 2014 annual overview of the regulation of nursing homes](#). This report also included the outcomes from our first thematic inspections in the area of food and nutrition and end-of-life care. We have also finalised and agreed a written understanding with SAGE, Support & Advocacy Services for Older People, which will enhance the care and welfare of older persons in many nursing homes.

New analysis of HIQA regulation of nursing homes

We have [published our overview report](#) of our regulation of public and private nursing homes for 2014.

We have [published our overview report](#) of our regulation of public and private nursing homes for 2014.

John Farrelly, our Head of Older Persons' Programme, commented: "Our analysis suggests that while nursing homes have become safer for residents, many centres must now improve care quality and the quality of life for residents. While most centres had an acceptable level of overall compliance with the regulations and standards, many needed to improve their individualised person-centred care planning and how that care is delivered. Improvements in their approach to risk assessment and risk management were also needed."

In 2014, we carried out 758 inspections of 549 centres, 58% of which were unannounced and 42% announced. We inspected 93% of nursing homes and published 707 inspection reports. The results highlight that in 4,371 cases, regulations and standards were met, while there were 3,436 non-compliances. In 2014, we asked providers to take 5,864 corrective actions to address non-compliances.

Mary Dunnion, our Acting Director of Regulation, commented: "Other findings show that providers will need to invest more in recruitment and training, and in ensuring that enough staff with the relevant skill mix are available to support residents. Improvements are also needed in end-of-life care and food and nutrition. Nursing homes must continue to ensure that the basics of safe care are in place, while prioritising and developing a culture of quality improvement and person-centred care."

The analysis also indicates that centres must make the transition from complying with regulations and standards to providing a truly individualised service for each specific resident. Some residents still live in large and outdated open-plan wards, with little privacy and dignity. Despite a five-year lead-in time to comply with requirements, at the end of 2014 a number of centres had yet to meet the physical environment requirements to protect and promote the privacy and dignity of residents.

In 2014, there was a substantial increase in registration activity. HIQA processed 268 registration applications, mostly driven by centres renewing their registrations (in 2013, 82 applications were processed). Six privately operated centres that had been on the register in December 2013 had closed by December 2014, while by the same date five new privately operated centres had been added to the register. Formal enforcement procedures were used in respect of one private centre.

There was a sharp increase in the level of concerns brought to HIQA about nursing homes in 2014. HIQA received 609 items of unsolicited information relating to 303 centres, of which just over half (55%) came from concerned relatives of residents. This is a 71% increase on the year before. In 2014, HIQA inspected 92% of centres which had been the subject of unsolicited information. Meanwhile, we also found examples of good care, such as dedicated person-centred plans for residents at end of life.

Mary Dunnion continued: "Good compliance was also seen in relation to suitable persons in charge, information provided to residents, complaints procedures, and safeguarding and safety. However, compliance data on safeguarding vulnerable older people indicates a need within the sector to better understand how to safeguard dependent older persons in their care."

During 2014, end-of-life care and food and nutrition were inspected specifically in 197 centres. John Farrelly concluded: "Good practice in both areas was found in most centres inspected, and at least 84% of centres were found to be fully or substantially compliant during the inspections. However, overall, 470 corrective actions were issued by the Authority in these two areas. To continue to promote safe care and the quality of life for all residents, we will be publishing revised standards for nursing homes later this year."

[Read the full report](#)

[Download the infographic PDF](#)



Children's team update

To date in 2015, our Children's Team has completed two child protection and welfare inspections of the Child and Family Agency's (Tusla's) Louth Meath and North Dublin service areas. We have also just published a new report on the Ballydowd Special Care Unit.

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The [reports of these and other inspections are published on our website](#). In addition, we have completed two foster care inspections in Tusla's Galway Roscommon and Cavan Monaghan West Leitrim service areas. Reports of these inspections will be published in due course.

In 2014, we undertook a thematic monitoring programme in relation to children's residential services which focused on the management of children's behaviour that challenges.

This programme was extended into 2015 with a further 10 inspections completed with the same focus. Other risk-based monitoring inspections of children's residential centres will take place as required.

Until late August, we had also carried out 43 inspections of designated centres for children with disabilities. Eight designated centres for children with a disability have been registered at the time of writing.

Ann Ryan, our National Head of Programme: Children's Services, commented: "In a number of the centres for children with a disability inspected, improvements were required in relation to assessments of the children's needs, care planning, risk management and quality assurance."

Meanwhile, before the end of the year, we will inspect the country's three special care units against [new Standards](#) published by us last March.

We have also published [an overview report of the regulatory activity of the Children's Team in 2014](#).

HIQA publishes overview of its regulatory activity for children's services during 2014

Our Children's Team inspectors placed particular emphasis on children's rights [during their inspections last year](#), and they met with and heard from a total of 202 children across a range of care settings.

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We are committed to ensuring that children's rights are upheld, particularly those in the care of the State.

At the end of 2014, there were 6,463 children in care in Ireland. Of these, 325 children were in a residential placement, 6,011 were in foster care and the remainder were in other care placements.

Sixteen children were in special care placements. During 2014, 40,000 children were referred to the Child and Family Agency's (Tusla's) child protection and welfare services.

Our Children's Team carried out 111 inspections in 2014 across a range of services, which included inspections of residential services, foster care and child protection and welfare services. The Children's team monitored and regulated services delivered by a number of different providers in the public, voluntary and private sectors.

[Our Annual report of the regulatory activity of the Health Information and Quality Authority: Children's Services 2014](#) was published in June, and covers statutory children's residential centres, statutory foster care services, child protection and welfare services, designated centres for children with disabilities and the country's detention schools.



While the overview report highlights areas where it is believed children's rights may have been breached, it also highlights findings of excellent child-centred practice. Information about their rights was readily available to children, they participated in their care planning meetings, and were supported in accessing their records and making complaints if they were unhappy. Practice in relation to managing, recording and resolving complaints was generally of a high standard.

However, we found significant variation in the performance of services provided by the Child and Family Agency (Tusla).

Commenting on the report, Mary Dunnion, our Acting Director of Regulation, said: "Data provided by the Child and Family Agency and our inspection findings revealed significant variation in the performance of the Agency in the different service areas. Notwithstanding, the HIQA overview also shows that the Child and Family Agency had made progress in improving some of its services."

[Read the Annual report of the regulatory activity of the Health Information and Quality Authority Children's Services 2014.](#)

[Download the Infographic](#)

New HTA on screening for atrial fibrillation in primary care

We have published a health technology assessment report on screening for a common abnormal heart rhythm called atrial fibrillation.

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Atrial fibrillation is the most common abnormal heart rhythm seen in general practice and is associated with a five-fold increase in the risk of stroke. It has a prevalence of around 5% in those over age 65.

There are about 8,000 strokes in Ireland annually, and approximately one in three of those are associated with atrial fibrillation. Atrial fibrillation screening aims to detect the risk of stroke in an individual as early as possible.

A screening programme for this condition is among the recommendations contained in the National Cardiovascular Policy 2010–2019, and work on a pilot screening programme has already been carried out in Ireland by the Health Service Executive (HSE).

Following a request from the HSE's Clinical Programme for Stroke, we carried out an evaluation of the clinical and cost-effectiveness of opportunistic screening in primary care. Our report outlining the results of this health technology assessment (HTA) is now available on our website, www.hiqa.ie.

It found that a national screening programme for atrial fibrillation for over 65s in primary care would likely be cost-effective in Ireland.

Our Director of Health Technology Assessment and Acting Deputy CEO Dr Máirín Ryan told *HIQA News*: "The results indicate that annual opportunistic pulse palpation during routine GP consultations for those over aged 65 would be considered cost-effective. Based on the best available evidence, annual screening for those aged 65 and older is expected to lead to reductions in the incidence and severity of atrial fibrillation-related strokes.

"This is assuming that those detected to be at risk by screening have a comparable risk of stroke as people detected through routine care. Our analysis estimates that screening would result in the detection of one additional atrial fibrillation case for every 22 people screened from age 65 onwards, and one stroke avoided for every 270 people screened over the same period."

Dr Ryan concluded: "A budget impact analysis found that screening would be associated with an incremental cost to the HSE of approximately €3.7 million over the first five years. This includes the additional costs associated with screening and with therapy in diagnosed cases, as well as the cost savings resulting from a gradual decrease in the incidence of stroke over a period of five years."



Dr Máirín Ryan, HIQA's Director of Health Technology Assessment and our Acting Deputy CEO

HIQA review of antimicrobial stewardship in public acute hospitals

We have received self-assessment data from public acute hospitals as part of our review of antimicrobial stewardship in these hospitals.

We have received self-assessment data from public acute hospitals as part of our review of antimicrobial stewardship in these hospitals.

In line with our responsibility for monitoring compliance against the *National Standards for the Prevention and Control of Healthcare Associated Infections*, we have developed an inspection programme focused specifically on antimicrobial stewardship in public acute hospitals.



Antimicrobial stewardship refers to a set of coordinated strategies which aim to improve the quality of use of antimicrobial medications, with the goal of improving patients' health outcomes, reducing adverse effects, reducing the emergence of resistance, and reducing healthcare costs.

HIQA's Acting Director of Regulation, Mary Dunnion, said: "Antimicrobial resistance is a challenge affecting the entire health service. After a period of time, resistance emerges in antibiotic use. Antimicrobial stewardship acts to combat this resistance by ensuring the value of antimicrobial agents currently in use is preserved for as long as possible through careful and expert usage."

We recently published [a guide to our review](#), which consists of two parts: a process of self-assessment followed by announced inspections in a selection of hospitals. All 49 public acute hospitals in the country — which are expected to have a wide programme of infection prevention and control already in place — were asked to complete a self-assessment and submit it to the Authority.

HIQA will carry out announced inspections in 14 of the 49 hospitals. Our review intends to identify and share good practice, and identify opportunity for improvement where it exists for the benefit of collective improvement across the system. The findings of the review will be made publicly available and published on the Authority's website, www.hiqa.ie, with an anticipated publication date within the first three months of 2016.

National standard demographic dataset and guidance

Our Health Information Team is revising the [National Standard Demographic Dataset and Guidance for use in health and social care settings in Ireland](#).

Our Health Information Team is revising the [National Standard Demographic Dataset and Guidance for use in health and social care settings in Ireland](#).

Part of the revision will involve a public consultation, and we would like to hear what you think about the draft standards once they are published.

A revised version of the standards for consultation will be available on our website shortly. Your comments will help inform the development of the final Standards.

Safety and Quality Improvement update

2015 has so far been a very busy year for our Safety and Quality Improvement Directorate, with work continuing on the development of multiple new sets of health and social care standards and the revision of older ones.

2015 has so far been a very busy year for our Safety and Quality Improvement Directorate, with work continuing on the development of multiple new sets of health and social care standards and the revision of older ones.


The [National Standards for the Prevention and Control of Healthcare Associated Infections](#) are currently under revision, with a meeting of our expert advisory group for this project due to take place in October.

We have started developing new standards for Ireland's maternity services, the *National Standards for Safer Better Maternity Services*, and the first expert advisory group meeting for this project is due to take place in late September. This follows [HIQA's recent investigation report into maternity services at Midland Regional Hospital, Portlaoise](#).

We have also commenced the development of the *National Standards for the Conduct of Adverse Incident Investigations* as had been requested in the [Chief Medical Officer's report on Midland Regional Hospital, Portlaoise](#).

We will shortly be launching guidance for communicating in plain English for providers of children's services and adult services. This was a collaborative piece of work developed with the National Adult Literacy Agency (NALA).

Marie Kehoe O'Sullivan, our Director of Safety and Quality Improvement, commented: "This document will be of particular use to inspectors as it provides guidance with regard to communicating in plain English ourselves and in monitoring to ensure that providers are communicating effectively with people who use the services and their families. The document and accompanying video will be available on our website following the launch."



Marie Kehoe O'Sullivan, HIQA's
Director of Safety and Quality
Improvement

Meanwhile, we are planning to publish our guidance document on *Promoting autonomy for people who use health and social care services* later this year.

International News Round Up

Update on recommendations on patient-safety surveillance

Our Health Information team has completed an international review of patient-safety surveillance systems, which will be published later this year.

Following the 2014 [report of the Chief Medical Officer of the Department of Health on perinatal deaths at Midland Regional Hospital, Portlaoise](#), our Health Information Directorate is developing recommendations on coordinating patient-safety surveillance in Ireland.

Later this year, we will also publish a separate report of an 'as is' analysis we are conducting of patient-safety systems and structures in place in Ireland. This will include our recommendations for Ireland on such systems.

The international review outlines new evidence on reporting and learning systems for patient-safety incidents in Europe. It examines the approaches undertaken in four international jurisdictions and regions, namely British Columbia (Canada), Denmark, England and Scotland.

A variety of approaches exist for reporting patient-safety incidents. England and Denmark use national reporting and learning systems, while there are well established provincial systems in Canada, such as British Columbia's Patient Safety and Learning System.

Rachel Flynn, our Director of Health Information, commented: "There is also considerable variation in the regulatory frameworks in place, with some countries having mandatory reporting systems supported by law, while other systems are voluntary.

"The importance of involving patients and service users in capturing patient-safety incidents emerged as a key area and some systems allow patients and their relatives to report directly into the system."

Efforts to standardise adverse-event reporting was seen across all jurisdictions, with each using their own classification system, closely aligned to the [World Health Organization \(WHO\)](#) International Classification for

The importance of coordinating and sharing patient-safety intelligence was a further key theme to emerge. Data sharing agreements are in place in some jurisdictions, while all of the locations also use their systems to deploy safety alerts.

Meanwhile, we are finalising the 'as is' analysis of systems in place in Ireland and will convene the inaugural meeting of an expert advisory group in mid September to assist with the development of key recommendations in this area.

WHO thanks humanitarian health workers

On the recent **12th World Humanitarian Day**, the **World Health Organization (WHO)** highlighted the contributions and sacrifices of health workers responding to five humanitarian crises involving more than 60 million people, and will be profiling their stories between now and the World Humanitarian Summit in May 2016.

WHO Director-General, Dr Margaret Chan, commented: "More than a decade since the first World Humanitarian Day, the demands on emergency responders are unprecedented, with 82.5 million people in 37 countries needing humanitarian assistance. The costs, too, are unprecedented, reaching an estimated US\$20 billion."

She said the WHO is leading the health response to five major humanitarian crises, where more than 60 million people, from West Africa to Yemen, urgently require a wide range of healthcare services. In 2014, WHO received 372 reports of attacks on healthcare workers and facilities in 32 countries, resulting in nearly 1,000 injuries and more than 600 deaths.

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