Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

HIQA News

Issue 18 — March 2017

Photocall — HIQA health information seminar

Pictured at our first national health information seminar, 'Better Data, Better Decisions,' were: Muiris O'Connor, Department of Health; and Phelim Quinn and Rachel Flynn from HIQA. The seminar was the first in a number of events to mark HIQA's 10th anniversary this May.

Message from our CEO, Phelim Quinn

Welcome to the latest edition of *HIQA News.*

We are about to embark on a new national survey of patients who have spent at least a night in a public acute hospital in Ireland. It is estimated that in excess of 27,000 people will be eligible to participate in the survey, which will make it the largest patient survey ever conducted in Ireland.

International evidence shows that the key to improving the quality of healthcare services is to listen to and learn from the feedback of patients.

In order to capture this feedback, we have joined up with the Health Service Executive (HSE) and the Department of Health to implement the first nationwide survey of patient experience in 40 hospitals in Ireland, called the National Patient Experience Survey.

This initiative will provide an opportunity to acknowledge the positive work that is carried out daily, and it will identify areas for improvement. Many people, including patients and patient representatives, were involved in planning the Survey questions.

Hospital staff will be crucial to ensuring the success of the National Patient Experience Survey. It is important that healthcare staff are aware of its benefits, and to this end, our Survey team organised eight information sessions for staff across six hospital groups.

Further information on the survey can be accessed on the dedicated survey website: www.patientexperience.ie.

We are particularly proud that this survey is happening in 2017 — a special year for HIQA as we mark our 10th anniversary. Much has changed in the health and social care landscape in those 10 years. While many challenges remain, we are committed to bringing about better and safer services for the people of Ireland.

HIQA was initially set up to regulate Ireland's health and social care sector and to promote quality and safety in services. Since then, our remit has grown and diversified substantially, and successive programmes for Government and policy proposals point to further development and expansion in our role in the coming years.

We want to use the opportunity of marking our 10th anniversary to look at what we can do further to make health and social care services safer and better for people using these services over the next 10 years and to support staff to continue to play a central role in that.

As you will see from this issue of HIQA News, all our teams are busy on a daily basis on various other projects and with inspecting and monitoring services. We want to continue to work constructively with all who provide and use services to achieve truly safer and better care.

Until next time, best wishes,

Phelim Quinn

HIQA publishes update on review of pre-hospital emergency care services

Sean Egan, HIQA's Acting Head of Healthcare Regulation

We have published a review of progress in implementing the recommendations of our 2014 review of pre-hospital emergency care services.

Our *review* found that despite progress in pre-hospital emergency care provision in Ireland, serious issues remain in the organisation of these services in the Dublin area.

Overall, HIQA found that more needs to be done to ensure that a modern, effective emergency ambulance service is provided by Ireland's two publicly funded services: the National Ambulance Service and Dublin Fire Brigade.

Sean Egan, HIQA's Acting Head of Healthcare Regulation, commented: "Since 2014, a number of key improvements have occurred in the provision of pre-hospital emergency care services. In particular, the National Ambulance Service move to a single control centre over two sites has been a major enhancement in service provision. Furthermore, the National Ambulance Service now has a very clear understanding of what it needs to do to progress services and is better governed and supported by the HSE to progress this improvement. However, the National Ambulance Service still lacks necessary capacity and, despite increased recruitment rates, remains reliant on overtime to maintain services."

A key finding of this review relates to the provision of services in Dublin. HIQA found a high level of risk associated with a lack of collective ambulance capacity and arrangements for call handling and dispatch.

Sean Egan continued: "In Dublin, it was clear to the HIQA Review Team that significant shortcomings remain that put patients at risk. While lines of communication, formal governance arrangements and working relationship at senior management level within the HSE and Dublin City Council were much improved, a detailed plan for the delivery of emergency ambulance services in the greater Dublin area still does not exist."

Read the report here.

Read the press release.

Update on the National Patient Experience Survey

The Minister for Health, Simon Harris TD, will shortly launch the new nationwide survey of patients who have spent a minimum of one night in a public acute hospital. The first patients are due to receive the **National Patient Experience (NPE) Survey** from 1 May.

Our Director of Health Information and Standards, Rachel Flynn, said this is "a significant milestone towards capturing the views of patients, and it will bring many benefits to staff". International evidence shows that the key to improving the quality of healthcare services is to listen to and learn from the feedback of patients.

In order to capture this feedback, we have joined up with the Health Service Executive (HSE) and the Department of Health to implement the first ever nationwide

survey of patient experience in Ireland, called the **National Patient Experience Survey**.

Both patients and hospital staff alike benefit hugely when the experiences of patients are used to promote quality improvements in the healthcare system. Using patient information for the planning of healthcare delivery has been linked with:

- improved clinical outcomes
- better relationships between clinicians and their patients
- improved hospital productivity and efficiency
- higher staff satisfaction rates.

The National Patient Experience Survey will provide an opportunity to acknowledge the positive work that is carried out every day in hospitals, and it will identify areas in need of improvement.

When is the survey taking place?

All adult patients who have spent a minimum of one night in a public acute hospital and are discharged during the month of May 2017 will be asked to complete a survey. Participants will have until 26 July 2017 to complete and return the survey.

How do we propose to measure patient experience?

The survey tool for the National Patient Experience Survey has been finalised. The NPE Survey questionnaire includes 58 structured tick-box questions and three open-ended (free-flow) questions from the Picker Institute's library of questions. Many people, including patients and patient representatives, policymakers, data analysts and academics, were involved in selecting the most important questions for the Irish healthcare context.

How do we engage stakeholders?

Hospital staff across the 40 participating hospitals will be the key to ensuring the success of the National Patient Experience Survey. They are the people who meet, care for and support patients. As such, they will play an important role in informing and encouraging patients to participate in the survey.

Because it is important that healthcare staff are aware of the benefits of the survey, the NPE Survey team organised eight information sessions across six hospital groups. The purpose of these information sessions was to inform staff and to outline the roles and responsibilities of staff and management in implementing the survey.

Rachel Flynn commented: "The information sessions were attended by senior management, quality and patient safety personnel, group communication managers as well as patient administration system (PAS) and information technology (IT) officers from six hospital groups. The information sessions were a great success as staff from across the system, including hospital group CEOs, welcomed the NPE Survey."

How do we ensure that patient data is kept safe and secure?

The National Patient Experience (NPE) Survey has undergone a privacy impact assessment and received ethical approval from the Royal College of Physicians of Ireland (RCPI). The Data Protection Commissioner has also been informed about the progress of the National Patient Experience Survey.

Data sharing agreements have been put in place between HIQA, each of the six participating hospital groups and the 11 participating voluntary hospitals.

Interested in finding out more?

You can keep up to date with all National Patient Experience news on:

- Twitter: twitter.com/NPESurvey
- Facebook: facebook.com/NPESurvey
- and on our website: patientexperience.ie.

Photo gallery — National Patient Experience Survey

Jude Cosgrove, Senior Analyst in HIQA, presenting on the National Patient Experience Survey at an information session in Limerick.

At the hospital information session in Naas were left to right: Cornelia Stuart (Assistant National Director, Quality Assurance and Verification, HSE), Rachel Flynn (Director of Health Information and Standards, HIQA), Margaret Brennan (Head of Quality and Patient Safety, Acute Hospitals Division, HSE) and our CEO Phelim Quinn.

Dr Susan O'Reilly (Group CEO, Dublin Midlands Hospital Group) opening the Dublin Midlands hospital information session on the National Patient Experience Survey, held in the Department of Health, Hawkins House, Dublin.

Opening the hospital information session in Galway were left to right: Rachel Flynn (Director of Health Information and Standards, HIQA), Jean Kelly (Group Director of Nursing, Saolta Hospital Group) and our CEO Phelim Quinn.

Investigation terms of reference

We have published Terms of Reference for the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla).

Terms of Reference

Section 9 Health Act 2007 (the "Act") Investigation

Investigation into the management of allegations of child sexual abuse (CSA) against adults of concern, by the Child and Family Agency "Tusla", upon the direction of the Minister for Children and Youth Affairs (the "Minister")

1. Direction of Minister to undertake a Section 9 investigation

On 02 March 2017 the Authority was directed by the Minister (pursuant to the Minister's power to do so under Section 9(2) of the Act) to undertake an investigation

(the “Investigation”) under Section 9(1) of the Act. The Minister believes that the apparent poor handling by Tusla of information provided to it, arising from the Garda Sergeant Maurice McCabe case, indicates a possible “serious risk to the health and welfare” of children. The Investigation required by the Minister is to be “of Tusla’s national practices in the handling of referrals of allegations of sexual abuse which involve adults of concern”.

2. Scope of Investigation specified by the Minister

In particular the Minister directed the Authority to provide in its investigation an assessment of the handling by Tusla of such referrals, at national and area level, having regard to the following areas:

- Current risk to children
- Fair procedure and due process for persons against whom allegations are made
- Bilateral engagements with An Garda Síochána, including monitoring or co-ordination of efforts
- An assessment of the number and mix of skilled and experience staff involved and if this is sufficient for the purpose
- Allegations being managed in a timely manner and an indication of reasons where they were not
- Management and control of information and data, both received and generated by Tusla.

3.Exclusions from Scope of the Investigation as directed by the Minister

The Minister has specifically directed that the Authority, in its Investigation, should take all necessary steps to avoid the potential for overlap with the Tribunal of Inquiry established to inquire into certain protected disclosures, arising from the protected disclosures made by Garda Sergeant Maurice McCabe (the “Tribunal”). In particular the Minister has directed that any files “relating to allegations of child abuse that come within the terms of reference of the Tribunal and, in particular, files concerning allegations of abuse of children against members of An Garda Síochána, are formally excluded from the Authority’s investigations”.

The Minister has informed the Authority that the Ombudsman is also currently considering some complaints about retrospective cases involving adults of concern and their handling by Tusla. Tusla has informed the Authority that the Office of the Data Protection Commissioner is conducting an investigation on the overall governance of data protection throughout Tusla.

Utilising the National Standards for the Protection and Welfare of Children, the investigation team will examine the effective management of information and the availability of adequate resources. However, the investigation will not include a comprehensive assessment of the number and mix of skilled and experienced staff involved nor will it include assessment of Tusla’s compliance to the Data Protection (Amendment) Act 2003.

4. Specific Terms of Reference of the Investigation

In conducting this Investigation, the Authority will investigate and assess against nationally mandated standards and evidence based practice how local, regional and national governance arrangements in Tusla, are supporting the effective management of child-sexual abuse ("CSA") referrals involving adults of concern (including allegations of CSA made by adults in relation to when they were children). This Investigation will be further to, and take account of, the existing information available to the Authority from its existing inquiries as part of its monitoring function under Section 8(1) (c) of the Act in relation to child protection services provided by Tusla.

The Investigation will be carried out on the basis of the following Terms of Reference:

(a) To carry out an Investigation into the safety, quality and standards of the services provided by Tusla in relation to referrals of allegations of child sexual abuse with particular regard to the areas identified by the Minister (and as set out in paragraph 2 above).

(b) In particular to investigate and assess how local, regional and national corporate governance arrangements provided by Tusla are supporting the effective management of CSA referrals involving adults of concern, including allegations of retrospective CSA.

(c) In particular to investigate and assess the efficacy of bilateral interactions between Tusla, An Garda Síochána and all relevant third parties.

(d) The Investigation will specifically include an assessment of the operational arrangements, including the oversight and monitoring processes in place, to ensure the timely screening, assessment, and management of:

A. CSA allegations involving adults of concern; and

B. Allegations of CSA which occurred in the past made by adults in relation to when they were children.

5. Recommendations and Reporting

If, in the course of the Investigation, it becomes apparent that there are reasonable grounds to believe that there are further or other serious risks to any children or persons receiving services, the Investigation Team may recommend to the Authority and/or the Minister that these terms be extended to include further investigation or that a new investigation should be undertaken, as appropriate.

The Authority shall, prepare a report of the findings of the Investigation and make national recommendations pertaining to Tusla's management of CSA allegations referred to it, to the extent that the Authority considers appropriate. The report will be submitted to the Board of the Authority for approval. This report will be published in

order to promote safety and quality in the provision of child protection services for the benefit and welfare of the public.

6. This Investigation will be carried out in accordance with Section 9 and all other relevant provisions set out in the Act. The Investigation will be conducted by an Investigation Team appointed and authorised by the Authority in accordance with Part 9 of the Act. The Team will carry out the Investigation and may exercise all of the powers available to it or its personnel under the Act, particularly those powers set out in Part 9 of the Act, including rights of entry, its rights to inspect premises, records and/or documents and its rights to conduct interviews and rights to require explanations in relation to documents, records or other information. In addition, the Authority (with appropriate Ministerial approval and in accordance with the Act, where required) may engage advisors as it considers necessary in the undertaking of this Investigation.

These Terms of Reference were approved by the Board of the Authority on 08 March 2017.

Work starts on National Standards for Children's Residential Centres

We have started work on developing national standards for children's residential centres.

This work is being undertaken in preparation for forthcoming legislative changes, namely new draft Health Act 2007 (Care and Welfare of Children in Children's Residential Centres) Regulations.

This will extend HIQA's registration and inspection functions beyond the statutory children's residential centres currently within our remit to also include the private and voluntary centres currently registered and inspected by the Child and Family Agency (Tusla).

We have started to prepare a background document to inform the development of the standards. This will include a review of Irish guidelines and policy documents, a systematic literature review and a review of international standards and guidelines.

The standards team is also convening a standards advisory group, the first meeting of which is scheduled to take in May. This will be the first of many steps in engaging with key stakeholders throughout the standards-development process.

It is anticipated that the national standards for children's residential centres will be submitted to the Minister for approval by the end of the year.

Children's team monitoring activity in 2017

Our children's team has embarked on a comprehensive series of monitoring activities and inspections in 2017. Some of our monitoring activity for 2017 includes:

Foster care services

Based on inspection findings of 2016, HIQA will carry out a programme of monitoring and inspection of the 17 statutory foster care services. These will examine the recruitment, assessment, approval, supervision and review arrangements in place for foster carers.

Children's residential centres

We will inspect all statutory children's residential centres. We will also continue to work with the Department of Children and Youth Affairs to progress the transfer of the registration and inspection function to HIQA for those children's residential centres operated by the private and voluntary sector.

Special care units

HIQA will continue a programme of monitoring and inspection of the country's three special care units. When the registration and inspection of these units is commenced under the Health Act 2007, HIQA will begin a programme of registration of the three special care units.

Oberstown Children Detention Campus

A full inspection by HIQA will be completed during the course of 2017.

New guidance on children's services inspections

We have revised our guidance for providers on HIQA's monitoring programme for child protection and welfare services, foster care services, residential centres, special care units and Oberstown Children Detention Campus in Co Dublin.

The revised guidance is available on our website www.hiqa.ie. It contains details of new descriptions of judgments — called judgment descriptors in HIQA — for 2017. We will judge a service or centre to be compliant, substantially compliant or non-compliant with the regulations and or standards.

These are defined as follows:

- **Compliant**: a judgment of compliant means that no action is required as the service and or centre has fully met the standard and is in full compliance with the relevant regulation, if appropriate.
- **Substantially compliant**: a judgment of substantially compliant means that some action is required by the service and or centre to fully meet a standard or to comply with a regulation, if appropriate.
- **Non-compliant**: a judgment of non-compliant means that substantive action is required by the service and or centre to fully meet a standard or to comply with a regulation, if appropriate.

Children’s team inspections in 2016

Over the course of 2016, the children’s team conducted 53 monitoring inspections of different services for children.

There were 40 monitoring inspections of statutory children’s residential centres, two of which were announced.

An unannounced monitoring inspection took place in each of the country’s three special care units.

We also carried out seven foster care monitoring inspections, three of which were private foster care services and four statutory foster care services. All of these monitoring inspections were announced.

In addition, three child protection and welfare monitoring inspections took place, all of which were announced. Full reports on each service inspected in 2016 are available on the HIQA website, www.hiqa.ie.

Smoking cessation HTA update

Dr Máirín Ryan, HIQA's Deputy Chief Executive and Director of Health Technology Assessment

HIQA has completed a national public consultation on a health technology assessment (HTA) of smoking cessation interventions.

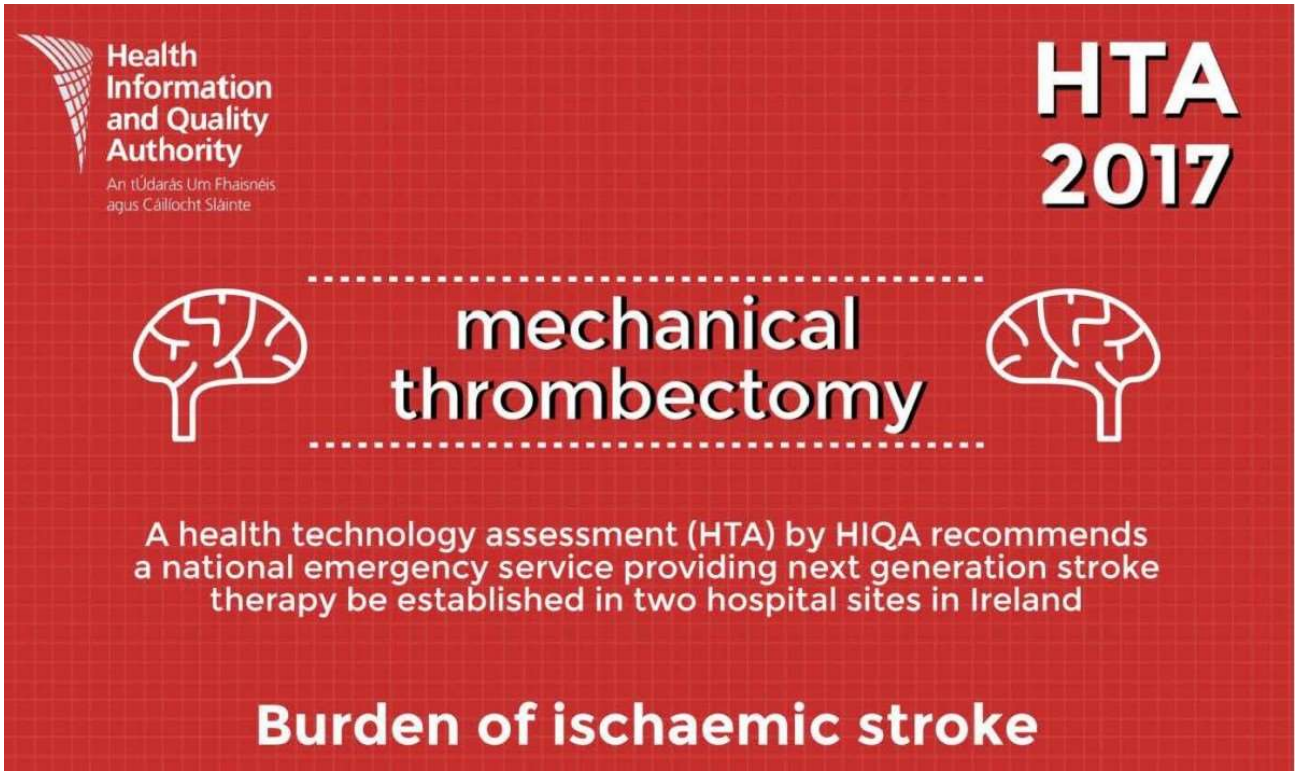
The final HTA is being submitted to the Minister for Health and the Health Service Executive (HSE) and will be published shortly.

This independent analysis identified how to improve the mix of such interventions, offered in Ireland by the HSE to increase overall quit rates at an acceptable cost.

The findings will also inform the development of a national clinical guideline to guide healthcare professionals and smokers on how best to quit smoking successfully.

Dr Máirín Ryan, HIQA's Deputy Chief Executive and Director of Health Technology Assessment, commented: "The assessment is the first of its kind in the EU to examine the cost-effectiveness of e-cigarettes."

HTA of mechanical thrombectomy for stroke



Extract from our infographic on our HTA of mechanical thrombectomy for stroke

Our health technology assessment (HTA) team has published a HTA recommending the establishment of a national emergency endovascular service for acute stroke in Ireland.

This service would provide next-generation stroke therapy in two hospital sites in Ireland for selected stroke patients.

Evidence shows that providing this treatment in addition to the standard medical care for stroke would enable an additional 57 patients to regain functional independence at 90 days after a stroke.

Dr Máirín Ryan, HIQA's Deputy Chief Executive and Director of Health Technology Assessment, commented: "The findings of the HTA indicate that in selected patients, mechanical thrombectomy using stent retriever devices is a safe and effective procedure when provided as an adjunct to standard medical care within six to 12 hours of onset of an acute ischaemic stroke.

"Based on an estimated 268 thrombectomy procedures undertaken each year, 57 additional patients (that is, increasing from 102 to 159) are predicted to regain functional independence at 90 days after a stroke. It also found that providing mechanical thrombectomy is cost-effective. The five-year budget impact of moving

from the current ad hoc service to an organised national service is estimated to be €2.8 million."

You can read the full HTA and press release here.

View our full infographic on this HTA.

HIQA at SPHeRE Network Annual Conference

Linda Murphy from HIQA at the SPHeRE conference in the RCSI on 12 January 2017

The work of our Health Technology Assessment (HTA) Directorate was presented at the SPHeRE Network Annual Conference in the Royal College of Surgeons in Ireland (RCSI), Dublin on 12 January.

HIQA's Eamon O'Murchu at the SPHeRE conference in the RCSI on 12 January 2017

The conference considers population and health services research, policy and practice throughout Ireland and Northern Ireland.

The theme of the 3rd SPHeRE Network Annual Conference was: "Supporting solutions: Connecting Research, Policy and Practice."

Dr Linda Murphy from HIQA spoke on the costing of cervical cancer, and Dr Eamon O Murchu from HIQA presented on the cost-effectiveness of smoking cessation.

Update from our disabilities team

Our disability inspection and registration team completed 163 inspections of residential care services for people with disabilities during the first two months of 2017.

Of these inspections, 38 were to inform a registration decision by HIQA, while nine others followed an application from designated centres to vary the conditions of their registration.

A further 11 inspections were carried out to inform a registration renewal decision by HIQA for centres that have now been registered for almost three years.

In this time, we issued 52 certificates of registration, registering the homes of 416 people. The sizes of these homes ranged from two for single residents up to a designated centre for 26 persons.

However, inspectors found that the quality of service to residents in 10 centres was poor and providers had failed to bring their centres into compliance with the regulations and National Standards.

We issued a notice of proposal to cancel the registration of these 10 centres. The providers may within a set time frame make a representation to HIQA setting out why registration should not be cancelled.

In a separate development, HIQA recently met with the forum of provider representatives. This forum, which has been meeting for some years now, allows representatives of service providers to discuss general queries and information items about the requirements of regulation and the inspection processes.

Residents of disability centres visit HIQA

Mary Dunnion, Chief Inspector of Social Services and Director of Regulation in HIQA

In late December 2016, our disability inspection and registration team welcomed a delegation of residents from designated centres for people with disabilities to our Head Office in Cork.

Mary Dunnion, Chief Inspector of Social Services and Director of Regulation in HIQA, commented: “These residents offered inspectors valuable feedback on our inspection processes and on how regulation has made improvements in their care, lives, opportunities and homes.

“Further engagements with residents’ groups are planned for 2017.”

News from our older people's team

Our older people's team continues to check compliance with regulations in nursing homes around the country and how centres are meeting the *National Standards for Residential Care Settings for Older People in Ireland*.

At the time of writing, the older people's inspection team had completed over 140 inspections of nursing homes in 2017. Almost half of these inspections were completed to inform the decision to renew the registration of these centres. This is because each nursing home must re-register with HIQA every three years.

In the coming year ahead, we will be making a decision on renewing the registration of approximately 237 nursing homes whose registration is due to expire in 2017.

The remainder of our resources this year will be focussed on completing evidenced-based inspections of dementia care provided in nursing homes, which are designed to encourage and facilitate quality improvement within the sector.

These dementia-themed inspections allow inspectors to gain an insight into residents and families' experience of care. They include discreet observation of interactions between residents and staff in order to assess if the care provided is person-centred.

In addition, we will continue to monitor centres that have been found in some areas to be non-compliant with the regulations and National Standards, and we take the necessary regulatory actions in response to improve the quality of care for residents.

Such action can include inviting a provider to meet with HIQA where the inspection findings are outlined to them; applying restrictive conditions; and finally, as a last resort, issuing a proposal to cancel a centre's registration and or take prosecutions.

In all cases, HIQA always places the lives of residents living in the centre to the fore when deciding on what course of action to take.

Meanwhile, we continue to engage with our stakeholders such as SAGE advocacy services and the Irish College of General Practitioners (ICGP). Once again, we wish to extend our thanks to the residents, their families and staff for their help and cooperation during our inspections.

New information management standards

Barbara Foley, our Health Information Manager, presenting at the seminar

Our new *Information management standards for national health and social care data collections* were launched by our CEO Phelim Quinn at the first national health information seminar, '*Better Data, Better Decisions'* in March.

Barbara Foley, Phelim Quinn and Rachel Flynn from HIQA formally launching our new Information Management Standards

These 10 new standards focus on the information governance practices and the management of national health and social care data collections in Ireland. HIQA is about to start a review programme of assessing compliance with the new Information Management Standards.

Dr Barbara Foley, our Health Information Manager, gave a presentation on our plans for this new review programme which aims to promote improvements in the governance, quality and use of data held by national data collections. Recognising that these standards are new, HIQA will continue to work with, and support, national data collections throughout the programme.

HIQA Health Information Seminar — 'Better data, Better decisions'

Members of HIQA's Health Information team at the health information seminar: Rachel Flynn, Cathy Duggan, Barbara Foley, Linda Weir and Julie Arnott

Our Health Information Directorate held the first national health information seminar, "*Better Data, Better Decisions*" on 1 March 2017.

This marked the first in a series of public events to celebrate HIQA's 10th anniversary this year.

The seminar had an exciting and diverse programme of speakers who emphasised the benefits of data quality and the importance of the best use of health data and information in decision-making. The seminar was an excellent opportunity for those working in national data collections in Ireland to meet, engage with, and learn from one another.

The opening address was given by Rachel Flynn, our Director of Health Information and Standards, followed by an overview of health information policy by Muiris O'Connor from the Department of Health. This was followed by a keynote presentation by our international speaker, Mona Heurgren, Director of the Swedish National Board of Health and Welfare, in relation to her work on the Swedish National Quality Registries.

In addition, there were also speakers from Irish national data collections such as CIDR (Computerised Infectious Disease Reporting), the HRB (Health Research Board) and the National Office of Clinical Audit (NOCA), including a presentation

from the newly appointed Director of the National Cancer Registry, Professor Kerri Clough-Gorr.

Rachel Flynn from HIQA commented: ”The speakers presented excellent examples, from both Ireland and internationally, of how quality data can be collected and used to improve the safety and quality of health and social care. The seminar was extremely well received, and it was recognised that there is a need for continual engagement and collaboration from all those working within the health information environment in Ireland.”

Over 150 delegates attended on the day, with representatives from a wide range of healthcare and related organisations including those from national data collections, the Department of Health, the Health Service Executive (HSE), clinicians, researchers, academics, and various other relevant stakeholders. There was also significant engagement on social media with the Twitter seminar hashtag #betterdata4health.

New health data booklet

Our Health Information team has launched a guidance booklet on *Five quality improvement tools for national data collections*.

The booklet was launched at the first national health information seminar, "*Better Data, Better Decisions*" on 1 March 2017.

This guide sets out tools and supports for national data collections to use to improve their information management practices and work towards meeting the *Information management standards for national health and social care data collections*.

This is the first in a series of brief guides that will be produced to help national data collections improve their information management practices.

New health information technical standards published

Rachel Flynn, our Director of Health Information and Standards

Our technical standards team has published two new standards, which are now available on our website.

The *National Standard for a Procedure Dataset including a Clinical Document Architecture specification* and *A National Standard for a Dispensing Note Dataset including a Clinical Document Architecture specification* were published in January.

The procedure standard was developed to standardise how clinical procedures are recorded and to facilitate easier sharing of information within and between health and social care services.

This national standard is part of a suite of standards that we have developed to support the standardisation of patient summaries. It complements our work in relation to the international review of patient summaries which we published in June 2016.

The dispensing note standard supports the sharing of information on the medications supplied by a dispensing pharmacist to the patient when fulfilling a prescription.

The scope of this standard is to define a minimum dataset of medication or medications dispensed to a patient in a community pharmacy for use in a summary care record. This standard follows the prescription dataset previously developed by our technical standards team.

Rachel Flynn, our Director of Health Information and Standards, commented: “Both of these standards are important enablers for transforming healthcare by facilitating timely access by healthcare professionals to accurate and up-to-date information As one of the lead organisations in supporting the eHealth vision for Ireland, HIQA is committed to a programme of work that supports the implementation of the *eHealth Strategy for Ireland* published by the Department of Health in 2013 and the *Knowledge and Information plan* published by the Office of the Chief Information officer in 2015.”

Medication safety in public acute hospitals

Sean Egan, HIQA’s Acting Head of Healthcare Regulation

We monitor medication safety in public acute hospitals against the *National Standards for Safer Better Healthcare*, and have published our first inspection reports in this area.

Our inspections found that where hospitals had effective medication safety governance arrangements in place, patients were better protected from potential harm related to medication use.

HIQA's medication safety monitoring programme, which started in November 2016, aims to examine and positively influence the adoption and implementation of evidence-based practice in this field in public acute hospitals.

Our *Guide to the Health Information and Quality Authority's Medication Safety Monitoring Programme in Public Acute Hospitals* outlines the requirements for service providers under phase one of the inspection programme.

Sean Egan, our Acting Head of Healthcare Regulation, commented: "Error associated with medication use constitutes one of the major causes of patient harm in hospital. Medication safety should be a priority area for all acute hospitals as they seek to ensure a high-quality and safe service for patients."

Seven medication safety inspections were carried out by HIQA between November and December 2016. HIQA found a wide variation in the medication safety arrangements in place across the seven hospitals.

A number of examples of good practice in relation to medication safety were found during these inspections. Examples of good practice included the following:

- medication safety was effectively supported by senior management in the hospitals
- a formal and structured medication safety programme was established
- an open incident and near-miss reporting culture was promoted, and a process was in a place for learning from medication-related incidents
- medication safety audits were carried out and learning was shared with all staff
- up-to-date medication policies were in place
- good leadership was shown from key clinical staff to support medication safety.

However, these inspections also found that learning from those hospitals that have more advanced medication safety programmes in place should be shared nationally, as more needs to be done in other hospitals to better promote safer use of medicines.

Sean Egan stated: "A key building block for any medication safety programme is the presence of an effective governance committee — usually known as a drugs and therapeutics committee — which oversees how the hospital anticipates, monitors, identifies and responds to risk related to medicines' use.

"As a first step, poorer performing hospitals need to improve how these committees function and, where possible, liaise with other hospitals to benefit from their experiences. Some hospitals also lack some necessary resources which would assist in promoting greater safety in the use of medicines. Further support in this regard may help to improve medication safety for patients."

Prevention and control of healthcare-associated infections

Our healthcare team is revising HIQA's approach to monitoring against the *National Standards for the Prevention and Control of Healthcare Associated Infections*.

This approach will include a process of self-assessment, followed up with unannounced inspection in hospitals to verify findings from the self-assessment.

Sean Egan, our Acting Head of Healthcare Regulation, commented: "These unannounced inspections will focus on a number of key care pathways related to infection prevention.

"We also intend to introduce a programme of monitoring through unannounced inspection in the area of decontamination of reusable invasive medical devices in early 2018. This new programme will be devised in 2017 and will be formulated with the assistance of an external advisory group."

We will publish guidance documentation prior to starting these programmes. HIQA is also in the process of conducting information-sharing sessions with hospital groups to provide further details in relation to these planned programme changes.

Meanwhile, our unannounced inspections against the National Standards continue. We published two inspection reports in February 2017 in relation to:

- University of Limerick Hospital Ennis
- Roscommon University Hospital.

These reports are available here.

Hospital nutrition and hydration update

We monitor nutrition and hydration care in public acute hospitals to determine if the hospitals are meeting the *National Standards for Safer Better Healthcare*.

Our inspections check that hospitals routinely have good care systems in place for patients who at are risk of malnutrition and dehydration.

Nine HIQA nutrition and hydration inspection reports have been published to date this year. These published reports relate to inspections in:

- St James's Hospital, Dublin
- Letterkenny University Hospital
- South Infirmary Victoria University Hospital, Cork
- Cappagh National Orthopaedic Hospital, Dublin
- St Luke's Radiation Oncology Network, Dublin
- Wexford General Hospital
- Louth County Hospital
- Mayo University Hospital
- Mercy University Hospital, Cork.

You can find out more about HIQA's nutrition and hydration monitoring function here.

Revised standards for preventing and controlling healthcare-associated infections

We have finalised new national standards for the prevention and control of healthcare-associated infections in acute healthcare settings.

After the public consultation on our draft standards, our Standards Advisory Group met to review changes we made based on submissions received.

The revised draft standards were approved by the HIQA Board and subsequently submitted to the Minister for Health for approval in January 2017.

The revised standards cover eight themes including person-centred care and support, effective care and support, and safe care and support.

Compared to the 2009 standards, there are new standards on the decontamination of equipment, risk management, quality improvement, management of information, procurement of equipment and health and wellbeing of patients.

With the aim of putting the patient at the centre of care, these revised standards place an increased focus on communication with the patient. Standards relating to workforce training and governance structures were also strengthened within the revised standards.

Following Ministerial approval, we will publish the Standards on the HIQA website along with a background document outlining the evidence-base that informed their development. We will also publish a statement of outcomes from the public consultation.

National Standards for the Conduct of Reviews of Patient Safety Incidents

The Mental Health Commission (MHC) and the Health Information and Quality Authority (HIQA) have developed National Standards for the Conduct of Reviews of Patient Safety Incidents.

The final meeting of the Standards Advisory Group was held in January and the draft standards were subsequently approved by the Boards of both organisations. The final Standards have been submitted to the Minister for Health.

The Standards were commissioned by the Department of Health and are underpinned by findings from the Chief Medical Officer's 2014 report, *HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).*

This 2014 report had recommended the development of national standards on the conduct of reviews of patient safety incidents, following the identification of shortfalls with the current system in Ireland.

Designed to apply to acute hospitals and mental health services across Ireland, these Standards aim to promote a framework for best practice in the conduct of such reviews and intend to set a standard for cohesive, person-centred reviews of such incidents.

Following Ministerial approval, the Standards will be published on the websites of both organisations along with a background document outlining the evidence-base used to inform the development of the standards. A statement of outcomes of the public consultation will also be published.

National Standards for Safer Better Maternity Services

Pictured is Fiona Cullinane from HIQA speaking on the maternity standards at the HSE West-Midwest Nursing and Midwifery Research and Innovation Conference in Limerick

HIQA developed the *National Standards for Safer Better Maternity Services* to make maternity care safer and better, and to ensure that the services delivered meet the needs of the women they are supposed to serve. They were launched by the Minister for Health Simon Harris TD last December.

Fiona Cullinane, our expert clinical lead on the development of the new Standards, gave a keynote address on the National Standards at the HSE West-Midwest Nursing and Midwifery Research and Innovation Conference on 1 March 2017. The conference was attended by approximately 140 nurses and midwives.

The Minister for Health Simon Harris TD (centre) launched our National Standards for Safer Better Maternity Services last December. Also pictured are our CEO Phelim Quinn (left) and our Chairperson Brian McEnery.

Update on new HIQA website

Our redesigned website is creating greater engagement with those using it since it was launched on 17 February, with more people stopping to read or interact with the site in some way.

The new site has been completely revamped to make it compatible with mobile phones and tablets, making it much easier for people to navigate. We have refined it further since the new site was launched.

Our Webmaster Cormac Farrell explains: “We have taken feedback from several members of the public in relation to how they would like to search for reports and publications. We have taken their feedback on board and as a result refined the way the search works within reports and publications, which has produced better search results.

“Analytical data from when we launched our new website in February shows we have been getting more engagement on the site. By comparison to the same time last year, the numbers using the site have increased by more than 4%, while there has been a 55% increase in webpages being viewed. On average, each person is viewing 50% more pages and spending over 5% longer on each page.

“It is also encouraging that the number of people who alight briefly on our website without interacting with it in any way has fallen (7.87% less). Meanwhile, there has been a 25% increase in visitors accessing www.hiqa.ie on their mobile phones. All this means that the new website is encouraging more repeat visitors and signals that it is more user-friendly and accessible.”

The website’s new features include:

- a dedicated reports and publications area
- advanced keyword search
- mobile- and tablet-friendly access.