



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Regulation of
Health and Social
Care Services

Overview report on the monitoring of healthcare services against national standards in 2018

October 2019

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

Setting standards for health and social care services — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

Regulating social care services — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

Regulating health services — Regulating medical exposure to ionising radiation.

Monitoring services — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

Health technology assessment — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

Health information — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

National Care Experience Programme — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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A message from the Director of Regulation

Welcome to our overview report on the monitoring work undertaken in 2018 by the Health Information and Quality Authority (HIQA) in public hospitals against various national standards that we monitor against in these hospitals. It details the approach taken by HIQA and summarises our findings across multiple monitoring programmes conducted throughout the year.

HIQA's role is to promote continual, sustained quality improvement in healthcare services. We are committed to ensuring that our work is relevant and is focused on those areas that make care safer and more effective for patients, and which complements the 'Sláintecare' report on future healthcare policy in Ireland.^{*1}

During our monitoring in public hospitals in 2018, we observed improvements in how a number of key patient-safety concerns were managed — in what is an often extremely challenging environment for patients, staff and management. However, recurring and persistent issues continued to hamper the delivery of the best possible care in our hospitals.

In 2018, HIQA carried out 38 inspections in 36 public acute hospitals to assess the quality of care in specific areas of concern in relation to patient safety, including infection prevention and control and medication safety. We enhanced the approach to monitoring both these areas during 2018 to help support systematic improvements in the quality of services, based on evidence and research.

Our infection prevention and control programme examined the management of multidrug resistant organisms in 17 hospitals — following the declaration by the Minister for Health of a public health emergency on this issue. It also conducted an initial review of the arrangements in place in six hospitals to ensure the safe decontamination and reprocessing of reusable medical devices. We updated our medication safety programme in 2018 to add a focus on high-risk medications and high-risk situations.

During 2018, HIQA also prepared for and began inspecting maternity hospitals and maternity units to assess their implementation of the *National Standards for Safer Better Maternity Services*, with a specific focus on obstetric emergencies. This programme continued into 2019 and, once completed, we will publish an overview report and individual hospital or unit inspection reports.

In 2018, we also prepared for the inspection of 23 public rehabilitation and community inpatient healthcare services. These are neither acute services nor based in acute

* 'Sláintecare' is a vision for a new health service in Ireland, which is detailed in the report from the Oireachtas Committee on the Future of Healthcare published in May 2017.

healthcare settings, but provide a range of vital healthcare services. Inspections of these services commenced in 2019.

Throughout 2018, HIQA identified an improvement in both overarching governance and the degree of implementation of national standards relating to infection prevention and control of healthcare-associated infections across hospitals. In particular, significant improvement was noted in relation to managing multidrug resistant bacteria that produce CPE (Carbapenemase Producing *Enterobacteriales*)[†] throughout 2018 and into 2019. We believe the establishment of a National Public Health Emergency Team in response to the increase of CPE in Ireland, allied to a targeted increase in public funding to address this issue, played a significant role in this improvement.

While HIQA believes more work is needed to fully respond to the threat posed by antimicrobial resistance nationally, there is potential to share valuable learning from the approach taken by the Health Service Executive (HSE) in more recent times to managing CPE at a national level. In particular, important and positive lessons can be drawn from how targeted national coordination and leadership within the HSE was deployed to more comprehensively face this threat. Such an approach is worthy of further consideration as part of ongoing efforts to address other areas of known patient safety concern.

Services provided by hospitals differ through both necessity and design across the State. However, during 2018, HIQA repeatedly found that the mechanisms that some of those hospitals had in place to reduce known patient safety risks did not always reflect the national standards. This finding has been particularly evident in HIQA's medication safety monitoring programme. While some of these deficiencies are related to resources, others relate to how services are locally organised, managed and led.

Moreover, those benefits already highlighted in the national approach taken to enhance infection prevention and control are less evident in the context of addressing medication safety-related risks. Hospitals and the HSE should consider adopting a similar national approach to medication safety as is being applied to managing CPE.

HIQA's experience, across both health and social care settings over the past 12 years, has demonstrated that monitoring and regulation is a positive influence on change. During 2018, HIQA continued to engage with both the HSE and the Department of Health to escalate risk issues identified through monitoring in the healthcare setting.

January 2019 marked a significant regulatory watershed for HIQA, as new legislation saw HIQA assuming responsibility for the regulation of medical exposure to ionising radiation in both public and private healthcare and dental services in Ireland. This new

[†] Carbapenemase Producing *Enterobacteriales* (CPE) are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are, therefore, much more difficult to treat.

function required HIQA to undertake a significant body of preparatory work throughout 2018.

However, HIQA's powers in relation to healthcare settings remain relatively limited. HIQA does not have the same powers of registration or enforcement within healthcare services as we have for older persons', disability and children's services.

We welcome the proposed expansion of our remit in the future. Legislative proposals include the Patient Safety Bill, which will extend our monitoring against national standards into the private sector. Meanwhile, the separate Patient Safety (Licensing) Bill envisages giving HIQA enforcement powers in the area of public and private healthcare.

While noting the impending expansion of our role and powers, this overview report aims to support collective improvement in services by highlighting high-level common findings identified through our current monitoring role. In doing so, we aim to positively influence the delivery of safer, better healthcare and protect the health and wellbeing of patients who depend on the health system today and into the future.

Finally, I would like to thank the patients, staff and providers in public hospitals for their continued engagement with HIQA and our work. We are aware of the challenging working environment in which care is delivered and in which patients receive care. We appreciate your ongoing commitment to working with us to provide safe, high-quality care to all people who depend on these services.



Mary Dunnion
Director of Regulation
Health Information and Quality Authority

1. Introduction

This report reviews HIQA's monitoring role in public healthcare services — as set out under section 8(1)(c) of the Health Act 2007 (as amended) — in 2018. It outlines inspection activity in public acute healthcare services to check compliance with national standards, reports on emerging and continuing challenges, and gives examples of good practice observed.

The report also outlines progress on developing and preparing for:

- HIQA's new monitoring programme for the country's maternity services;
- regulating medical exposure to ionising radiation in public and private healthcare and dental services;
- and monitoring healthcare organisations that provide inpatient rehabilitation and community healthcare services.

HIQA's role in monitoring healthcare services is directed by its legislative remit, national standards and evidence of what interventions reduce risks for patients and promote safe, effective and quality care. Global challenges set by international expert bodies, international evidence and research, and national priorities also inform HIQA's priority areas and its overall approach to monitoring.

The national standards that HIQA monitors in healthcare services include:

- *National Standards for Safer, Better Healthcare*²
- *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*³
- *National Standards for Safer Better Maternity Services*⁴
- *National Standards for the Conduct of Reviews of Patient Safety Incidents*.⁵

2. How we monitor healthcare services

In the healthcare setting, HIQA's current remit predominately extends to monitoring public hospital services against national standards under section 8(1)(c) of the Health Act 2007 (as amended). HIQA also has powers under section 9 of the Act to undertake a statutory investigation of a service or services.

HIQA's healthcare monitoring activity is informed by a number of different sources of information. Sources include solicited information, such as data requested from the

Health Service Executive (HSE) or the National Care Experience Programme,[†] or unsolicited information provided by the public about services (including patients, relatives and staff members working in healthcare organisations).[§]

While HIQA is unable to investigate individual complaints about a healthcare service, feedback given to HIQA is reviewed by healthcare inspectors to establish if services are safe, effective, caring and well managed. When required, HIQA engages with healthcare providers to seek assurances in relation to specific concerns and risks seen by HIQA or brought to its attention.

HIQA's monitoring of healthcare services is further informed by other publicly available key sources of information, such as healthcare review reports or international benchmarking data. Allied to this, HIQA conducts thematic monitoring inspections against relevant national standards in public acute hospitals. All of this information informs HIQA's overall understanding of how services are performing.

Thematic monitoring programmes

During 2018, HIQA focused on three key areas of patient safety in public hospitals using what is termed 'thematic monitoring programmes'. These measure and report on a service's compliance against relevant national standards, with a view to improving these services. The three key areas were:

- infection prevention and control
- maternity services
- medication safety.

Each thematic programme was developed by HIQA with support from a panel of experts in the relevant fields. The methodology and approach for each of these programmes was supported by international research, national guidelines and best practice.^{6,7,8,9}

Each programme has its own assessment and judgment framework (to guide inspectors with checking compliance and to allow providers to self-assess their own service) and lines of enquiry^{**} that set out how services are monitored against standards and what

[†] The National Care Experience Programme is a joint initiative from HIQA, the HSE and the Department of Health. It asks people about their experiences of care in order to improve the quality of health and social care services in Ireland. This initiative provides vital information to HIQA's Healthcare Team and is used as part of its monitoring programmes (see <https://yourexperience.ie/> for more information).

[§] Feedback is received by HIQA's dedicated Concerns Team, which provides advice and guidance as required. All information provided to HIQA is treated with confidence and in line with our privacy policy, which is available on the HIQA website, www.hiqa.ie.

^{**} Lines of enquiry are the key questions or prompts that inspectors use to help inform their inspection, assessment or investigation.

is expected of services. Further guidance on each thematic programme is available on the HIQA website, www.hiqa.ie.

Inspection activity during 2018

In 2018, HIQA conducted 38 inspections (see Table 1 on the following page and Appendix 1 for a list of hospitals inspected) across the three thematic programmes. Each inspection may be conducted over one or two days and involve a team of up to four inspectors on the same site for the entire day. Inspections also involve extensive review of information before and after the on-site part of the inspection and a feedback process with the hospital once a draft report is issued.

Inspections can be announced or unannounced as outlined below.

Announced inspections

HIQA gives hospitals two weeks' advance notice of a planned announced inspection. As part of the announcement of the inspection, hospitals are also asked to submit certain information, such as minutes of meetings and other documents for inspectors to review before the inspection. Announced inspections also allow HIQA to ensure that specific key personnel are available to meet with inspectors, as required by the inspection methodology applied for these types of inspection.

Unannounced inspections

This means that neither the hospital, person in charge nor any other person in the hospital has been informed by us in advance either formally or informally of our inspection. The inspectors simply turn up at the hospital to carry out the inspection.

Table 1. Thematic inspections conducted by HIQA in 2018

Thematic programme	Type of inspection ^{††}	Number of inspections	Announced or unannounced
Infection prevention and control	Monitoring against the <i>National Standards for the prevention and control of healthcare-associated infections in acute healthcare services</i>	17	Unannounced
Infection prevention and control - inspections of reprocessing reusable medical devices	Monitoring against the <i>National Standards for the prevention and control of healthcare-associated infections in acute healthcare services</i>	6	Unannounced
Maternity services	Monitoring against the <i>National Standards for Safer Better Maternity Services</i>	5	Unannounced
Medication safety	Monitoring against the <i>National Standards for Safer Better Healthcare</i>	10	Announced
Total		38	

†† Not all standards are inspected against as part of every monitoring programme and further information on standards and lines of enquiry are detailed in guidance documents available on the HIQA website, www.hiqa.ie.

Publication of inspection reports

In keeping with HIOA's values of being open and accountable, and communicating the nature and outcomes of its work, inspection reports are published on the HIOA website. Findings on inspections reflect what is found at a point in time, as levels of compliance against national standards can fluctuate over time.

3. Overall findings from HIQA monitoring in public acute hospitals during 2018

This chapter relates specifically to HIQA's collective findings obtained through inspections in two areas — infection prevention and control and medication safety. These are two areas that are internationally recognised as being known to place patients at significant risk.

A full list of these inspections can be found in Appendix 1 of this report. More detailed findings from each inspection can be found in the individual inspection reports, which are published in www.hiqa.ie. Findings from HIQA's maternity monitoring programme will be published following the completion of the programme.

3.1 Prevention and control of healthcare-associated infections

HIQA monitors infection prevention and control practice in hospitals against the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* (2017). In 2018, HIQA focused on two areas that are internationally recognised as being major contributors to potentially preventable patient harm as a consequence of healthcare provision.

One involved a detailed evaluation of how hospitals organise themselves to minimise the spread of healthcare-associated infections, with a particular focus on systems to detect, prevent, and manage multidrug-resistant micro-organisms. The other focused on the approach taken by hospitals to reduce the risk of critical and semi-critical^{‡‡} reusable medical device-related infection.

During 2018, nearly half of all public hospitals (23 hospitals) were inspected under the infection prevention and control monitoring programme. Seventeen of these inspections focused on the prevention and control of healthcare-associated infection, in particular systems to detect, prevent, and manage multidrug-resistant micro-organisms. Six inspections examined reusable-medical-device reprocessing in satellite decontamination facilities^{§§} outside of designated controlled decontamination units.^{***} The findings from both types of inspections are detailed below.

‡‡ The Spaulding classification, dating back to the 1950s, is a widely-used classification system which is used to determine the level of decontamination that a reusable medical device requires. The level of decontamination required depends on the equipment's purpose, and ranges from cleaning, through to disinfection to a requirement for sterilisation. Devices may be classified as 'critical' (presenting a high risk of infection transmission if not fully cleaned, disinfected and sterilised), 'semi-critical' or 'non-critical' (presenting a low risk).

§§ Decontamination facilities refers to the physical infrastructure where decontamination of reusable medical devices is provided.

***A controlled decontamination unit, such as a central decontamination unit or endoscope reprocessing unit, is a designated unit which has defined governance arrangements. It is designed, constructed, maintained and controlled

Background and context

Through monitoring the area of healthcare-associated infection for a number of years, HIQA has strongly advocated for an improved approach to the national coordination and leadership of infection prevention and control and antimicrobial stewardship in Ireland. This advocacy has been informed by concerns identified through its work related to national arrangements in this regard and due to increasing levels of antimicrobial resistance in Ireland and internationally.¹⁰

In October 2017, the Minister for Health activated a Public Health Emergency Plan^{†††} and convened a National Public Health Emergency Team as a public health response to the increase of Carbapenemase Producing *Enterobacteriales* (CPE)^{‡‡‡} in Ireland. The clinical significance of infection with CPE is considerable, with some outbreaks reporting a 50% mortality rate, or higher in the case of blood-stream infections, with CPE-producing bacteria.

Due to resistance to multiple antimicrobials, there are very limited therapeutic options available to treat infections caused by CPE. The spread of CPE in hospitals also leads to the closure of beds, wards and units. This in turn removes essential capacity to provide services, including to admit patients from emergency departments and to address waiting lists effectively.

The HSE introduced CPE screening guidelines for public acute hospitals in June 2017 to effectively manage this issue. Screening is a critically important measure in managing this patient safety threat and allows hospitals to better reduce the risk of colonised patients going on to develop CPE infection during the course of their medical treatment.¹¹ It also enables hospitals to better prevent potential spread of CPE to other patients and staff. These guidelines were updated in February 2018 with additional screening requirements to be implemented in all public hospitals from 1 March 2018.¹²

with structures, systems, processes and outcomes that are continuously monitored, measured and validated. This is to provide assurances that reusable medical devices are safely and effectively reprocessed consistently in line with legislation, manufacturers' instructions, national decontamination standards and guidelines, national standards and best practice guidance.

††† A National Public Health Emergency Plan was activated on 25 October 2017 by the Minister for Health in response to the increase and spread of Carbapenemase Producing *Enterobacteriales* (CPE) in Ireland. As a result, a National Public Health Emergency Team was convened and it has been meeting on a weekly basis since November 2017. Please refer to this Department of Health webpage for further details: <http://health.gov.ie/national-patient-safety-office/patient-safety-surveillance/antimicrobial-resistance-amr-2/public-health-emergency-plan-to-tackle-cpe/nphet-press-releases-minutes-of-meetings/>.

‡‡‡ Carbapenemase Producing *Enterobacteriales* (CPE) are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat. The routes of transmission of CPE from patient to patient are either by direct contact through carriage of CPE on the hands of healthcare workers, or indirectly via contaminated environmental surfaces or shared equipment.

In light of the ongoing national public health emergency, throughout 2018 HIQA focused on how hospitals were implementing the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*, with particular emphasis on systems to detect, prevent and manage CPE. Particular focus was put on CPE screening, and assessed this as a key measure of quality and patient safety in hospitals inspected.

Key findings for prevention and control of healthcare-associated infections

Overall, all 17 hospitals inspected were found to have clear lines of accountability and responsibility in relation to governance and management arrangements for the prevention and control of healthcare-associated infection.

A number of hospitals reported deficits in infection control team resources, including staff working in infection prevention and control, and microbiological laboratory support. Some others had acted to address some deficiencies previously identified by HIQA through inspection. For example, consultant microbiologist advice was available at a minimum level to meet national standards in all hospitals inspected — a situation that has not always been found during HIQA inspections in previous years. However, a small number of hospitals reported deficiencies in on-site consultant microbiologist cover.

All hospitals had systems in place to identify and manage risks in relation to the prevention and control of healthcare-associated infection. Risks identified in clinical areas were addressed at clinical-area level or were documented and escalated to directorate level or higher as required. Inspectors were informed by management that high risks were escalated in line with HSE risk management processes.

An increase in detection of CPE from screening samples on admission improves patient placement, reduces outbreaks and decreases the number of unexpected (thus late) detection from clinical samples, leading to less invasive CPE infection.¹³ However, HIQA found some variation in the implementation of the National CPE Screening Policy in hospitals inspected. At the time of inspection, over half of hospitals were not in full compliance with the February 2018 HSE guideline on screening patients for CPE. This meant that proactive infection control strategies might not have been routinely implemented to prevent CPE outbreaks in a timely manner, due to a lack of staff awareness of the presence of some patients being colonised with the organism.

Given that the threat associated with CPE was declared a national public health emergency, and given the very limited treatment options for patients who acquire bloodstream infection with a CPE-producing organism, HIQA views the lack of full compliance with national screening guidelines as a serious threat to patient safety. As a

result, HIQA escalated its concerns to HSE national management following inspections in 11 hospitals, in an effort to drive improvements in compliance levels.

As 2018 progressed, HIQA noted a steady improvement in the level of compliance with screening guidelines in most hospitals inspected. While full compliance with the screening guidelines was not achieved in some hospitals (often due to reported laboratory resourcing constraints), the overall number of patients screened in most hospitals increased, to include most if not all at-risk groups. This trend was also demonstrated in national CPE surveillance screening data, which showed a steady increase from around 10,000 CPE screens per month in early 2018, to around 19,000 per month in the latter months of the year.^{§§§}

The majority of hospitals inspected by HIQA in 2018 saw an increase in the number of detected CPE cases over a three-month period year on year (when 2018 was compared against the same period in 2017, see Figure 1). This increase is partly attributable to an increase in screening volume — further illustrating the importance of full visibility of this issue that is provided by more comprehensive screening of patients.

§§§ It should be noted that this figure has further increased incrementally in 2019, with a high of 24,463 screenings taken in April 2019.

Figure 1: Total number of CPE screenings in public acute hospitals per month between October 2017 and December 2018 and total number of positive screens over this time period.¹⁴

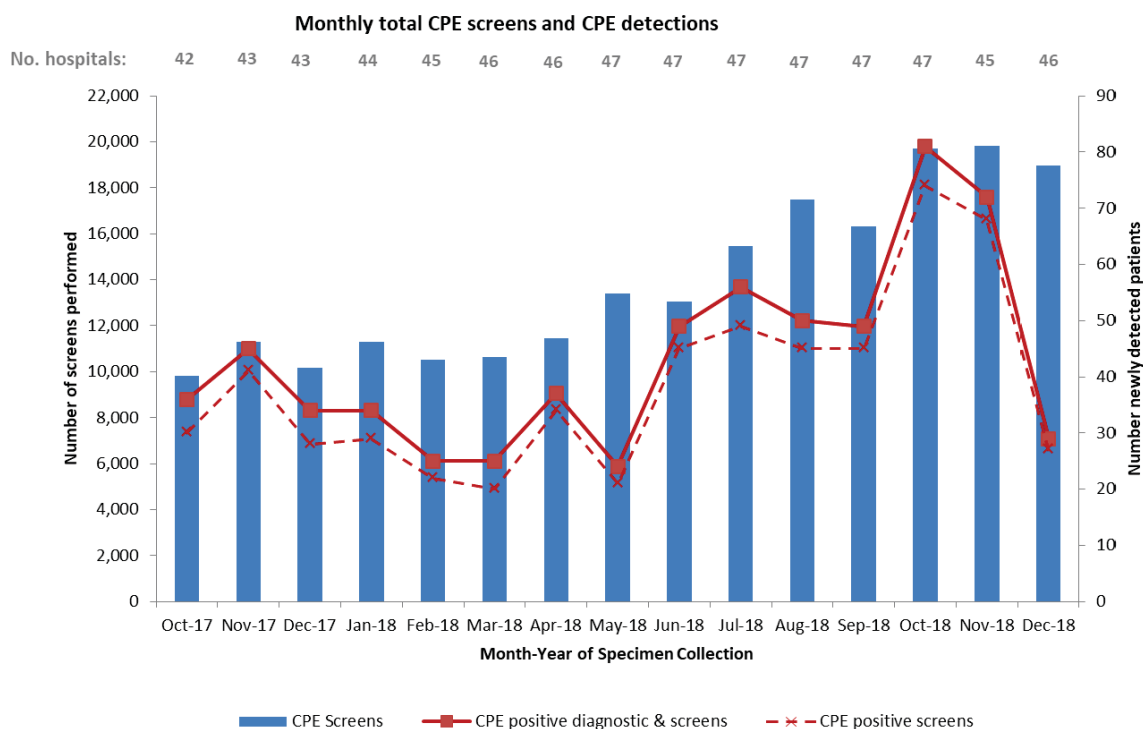


Chart reproduced with permission of the Health Protection Surveillance Centre.

Three of 17 hospitals inspected in 2018 were experiencing ongoing hospital outbreaks of CPE at the time of their inspections. These three hospitals had established specialist cohort wards to accommodate patients colonised or infected with CPE. Bloodstream infection rates in these hospitals remained at very low levels.

Improved national coordination and governance of the CPE threat, in the context of an overcrowded health system

During 2018, HIQA identified strengthened national leadership and governance across the HSE in relation to the CPE threat, including the bedding in of a National Public Health Emergency Team, which was convened in November 2017. A review of this team’s impact was outside the scope of this report. However, through its inspections, HIQA found progress achieved in individual hospitals was part of a wider trend of a more coordinated approach to CPE management nationally.

Although a number of multi-component infection control measures were used to prevent CPE infection and transmission, including antimicrobial stewardship[^] and the

[^] Antimicrobial stewardship describes a set of coordinated measures which aim to improve the quality of antimicrobials use, with the goals of improving patient health outcomes, reducing adverse effects, reducing the emergence of resistance and reducing healthcare costs. Source: Dellit TH, Owens RC, McGowan JE, Gerding DN, Weinstein RA, Burke JP, et al. Infectious Diseases Society of America and the Society for Healthcare Epidemiology of

implementation of transmission-based precautions,[‡] new cases of CPE continued to be identified. Recurring challenges faced by hospitals to effectively prevent and control these CPE outbreaks included a lack of patient-isolation facilities and high occupancy rates in the majority of hospitals.

HIQA found that dealing with CPE colonisation dominated the workload of infection prevention and control teams across the country throughout 2018. Because of additional pressures on these teams due to dealing with multiple CPE outbreaks, HIQA observed that teams were often hampered in their ability to contribute to education and training, audits of practice and the environment, and the revision and development of policies. HIQA believes infection control professionals need to be supported with resources, authority and time to maintain effective infection prevention and control services.

HIQA identified improving levels of compliance in hospitals in relation to implementing the national standards and HSE guidelines. Key findings in this regard included that:

- the majority of clinical areas inspected were generally clean
- oversight of performance across all clinical areas in relation to infection prevention and control was facilitated by ongoing microbiological surveillance, monitoring and audit programmes
- regular performance updates in relation to antimicrobial stewardship reported through established infection prevention and control governance structures were evident
- there was application of appropriate transmission-based precautions
- some hospitals had invested in technology to assist with rapid CPE microbiological testing
- nursing admission documentation incorporated an infection prevention and control risk-assessment in relation to multidrug-resistant organisms.

America Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship. *Clinical Infectious Diseases*. 2007; 44(2): pp.159-77. Available online from: <http://cid.oxfordjournals.org/content/44/2/159.full>.

[‡] Transmission-based precautions are additional precautions that staff need to take when standard precautions may be insufficient to prevent cross-transmission of specific infectious agents. Transmission-based precautions are categorised by the route of transmission of infectious agents (some infectious agents can be transmitted by more than one route) including contact, droplet and airborne precautions. Examples of transmission-based precautions in a residential care facility, for example, may include using single rooms, limiting social activities and restricting residents to their rooms as much as possible, and restricting visiting.

Opportunities for improvement in the prevention and control of healthcare-associated infections

Against a background of overall improvement, HIQA also identified a wide degree of variation in performance between the 17 hospitals inspected in this area in 2018. A number of factors which had the potential to contribute to outbreaks of CPE were identified by inspectors during the year. These included:

- a lack of clarity of the requirements for routine assessment and screening for multidrug-resistant organisms, such as CPE, among some staff
- an absence of dedicated software to aid surveillance of infections in most hospitals
- inconsistent application of transmission-based precautions in some hospitals
- deficits in equipment hygiene and oversight of equipment hygiene were identified in almost two out of three inpatient wards inspected. The non-compliances observed during the 2018 inspections showed that equipment — particularly frequently-used patient equipment, such as IV trays and commodes — were not being fully cleaned in line with national and evidence-based guidelines. Staff must be properly trained and consistently comply with procedures for human-waste management, bedpan reprocessing and equipment operation
- deficits in hospital infrastructure, which had the potential to impact on infection prevention and control measures, were often identified during inspections. Inspectors were informed in most hospitals that the number of single rooms was insufficient to manage the ever-increasing number of patients requiring isolation for infection prevention and control reasons
- the physical environment in a large number of hospitals inspected had not been maintained according to relevant national and international standards to reduce the risk of infection to patients and as such were not compliant with the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*. Inspectors observed ward-wide issues related to maintenance. Inspectors saw worn and poorly-maintained surfaces, finishes, flooring and some furnishings in patient rooms, including windows, wall paintwork, woodwork and wood finishes. As such, the standard of maintenance did not facilitate effective cleaning.

Inspections of reprocessing reusable medical devices

A recognised area of risk in relation to the transmission of infection in hospitals is the decontamination and reprocessing of reusable medical devices.^{15,16,17} If devices such as surgical instruments and endoscopes are not properly cleaned, decontaminated and reprocessed between patients, there is a potential for the transmission of infection. Previous outbreaks of infection related to reusable medical devices have been associated with breaches of approved reprocessing guidelines.^{18,19}

Reusable medical device pathways (both critical and semi-critical) — from patient use through to the decontamination process and final storage — must be planned, controlled, monitored and validated to provide ongoing assurances of the effectiveness of every element of the life cycle of reusable medical devices.

As part of its monitoring programme for 2018, HIQA began a specific programme of inspection in the area of reusable medical device decontamination and reprocessing to ensure patient safety when using reusable medical devices. The initial focus of these inspections was on satellite decontamination facilities outside of designated controlled decontamination units, for example, in outpatient, radiology and emergency departments.

Six thematic inspections on the decontamination and reprocessing of critical and semi-critical reusable medical devices were undertaken by HIQA in 2018. In 2019, HIQA continues to focus on the approach taken by public acute hospitals to reduce the risk of reusable medical device-related infection.

Key findings for reusable medical device reprocessing

Overall, HIQA found clear lines of accountability and responsibility in relation to governance and management of decontamination services in all six hospitals inspected in relation to the reprocessing of reusable medical devices.

Additionally, three of the six hospitals had assigned a local decontamination lead with responsibility for decontamination service provision, while all hospitals had an authorised engineer for decontamination.^{****}

Risk and incident management systems relating to decontamination and reprocessing of reusable medical devices were in operation in all hospitals. Incidents were reported through hospital-incident management systems and to the National Incident Management System.^{†††} In response to risks posed by inappropriate central

****A suitably qualified person designated by management to provide independent auditing and technical advice in relation to decontamination facilities, equipment testing and validation of records.

††† The State Claims Agency's National Incident Management System is a risk management system that enables hospitals to report incidents in line with their statutory reporting obligations.

decontamination facilities in three hospitals, and as a risk mitigation measure, surgical instrument decontamination had been outsourced to either an external company or another hospital within the same hospital group.

Strong and reliable track and trace systems^{†††††} verify that reusable medical devices have been decontaminated effectively. They also allow retrospective tracing of the patient on which a reusable medical device was used on, in the event of exposure to potential risk. While such systems were in place in five of the six hospitals inspected, one hospital had not implemented a track and trace system for Ear Nose and Throat endoscopes reprocessed in an outpatient department. HIQA considered this to be a high risk and sought assurance from hospital management about how this risk was being managed following the inspection. As a result, the hospital provided written assurance to HIQA following this inspection outlining measures taken to mitigate this risk issue.

A notable finding during the six inspections in 2018 was that academic training for staff working in centralised decontamination facilities was progressing across the hospitals, in line with HSE recommendations. In addition, the rollout of the HSE's national electronic track and trace systems for surgical instrument and endoscope reprocessing was evident across all hospitals inspected.

Opportunities for improvement

While acknowledging the small sample number of inspections undertaken in reusable medical device decontamination and reprocessing, HIQA found that there was still a need for some hospitals and or hospital groups to nominate dedicated personnel to lead the decontamination process, in line with national recommendations.^{3,20,21,22}

Additionally, at an individual hospital level, some decontamination services need to produce an annual decontamination quality assurance report. This report should be made available to staff and senior management identifying risks, near misses and measures put in place to minimise the risk of reoccurrence, in order to share learning.

It was evident that further investment was required to fully implement national standards and recommended practices in relation to decontamination service provision in all hospitals inspected. In the interim, hospital managers need to be assured that measures to control any hazards or risks in relation to these services are effectively implemented and monitored. A number of hospitals needed to reduce the number of satellite decontamination services and centralise decontamination activity. They also

^{†††††} Track and trace systems record the decontamination process used on critical and semi-critical reusable medical devices and link them to the patient on which they have been used.

needed to enhance facility design, storage systems and ventilation requirements and progress with environmental microbiological periodic testing regimes in line with HSE standards.^{21,22} In recent years, a national medical device equipment replacement programme had been put in place. However, some hospitals reported that more recent funding deficits meant they faced ongoing challenges from ageing equipment in need of replacement.

Some additional opportunities for improvement identified by HIQA included the need to embed a culture of regular review and continual audit, feedback and quality improvement cycles in relation to decontamination and reprocessing service provision.

During 2018, other aspects requiring improvement with decontamination and reprocessing of reusable medical devices included the need to ensure:

- the implementation of validated automated decontamination systems and electronic tracking and tracing systems for all critical and semi-critical reusable medical devices
- the timely review of decontamination and reprocessing-related policies and procedures
- cleaning specifications and hygiene auditing regimes are in line with national recommendations for higher-risk functional areas
- continued progress with academic education and training and regular review of staff competencies for all staff involved in providing decontamination services.

Conclusion on infection prevention and control monitoring

Overall findings under this area of thematic monitoring found both positive improvement in meeting some aspects of the standards, and a requirement for further improvement with respect to others. In taking a high-level view of overall efforts to meet these standards, HIQA notes that the underlying fabric and ageing infrastructure of some hospitals continues to present ongoing challenges to their maintenance and adherence to best practice and national standards.

Infection prevention and control best practice is also severely hampered by persistent overcrowding in the hospitals inspected. Nonetheless, it is essential that hospital environments are maintained at a high standard to ensure the effectiveness of infection control and decontamination practices and to prevent the transmission of infection.

HIQA found generally that progress had been made in meeting national guidelines and standards in relation to decontamination of reusable medical devices in the six hospitals inspected. These hospitals were working to implement the national standards and HSE best practice guidance in relation to decontamination and reprocessing of reusable

medical devices in the satellite decontamination facilities inspected. In addition, hospital managers regularly reported that the HSE's national lead official in the field of decontamination provided effective ongoing support with implementing national guidance.

Nevertheless, it is imperative that the HSE builds upon the progress made at a local level to ensure full implementation of decontamination requirements as identified in national standards and best practice guidance,^{21,23,24,25,26} relevant medical device legislation²⁷ and best available evidence.²⁸

During 2018, HIQA found that the 17 hospitals inspected had made efforts to address the ongoing CPE public health emergency, both within the confines of their budgetary allocations and the continuing pressures of insufficient bed capacity in the face of increasing clinical demands. However, HIQA also found that full compliance with national guidance around screening was not always present at the time of each inspection.

As a result of its inspections, HIQA emphasised firmly the need for hospitals to implement national guidance around screening. Where deficiencies in meeting national screening guidelines were found, HIQA escalated concerns within the HSE in an effort to influence the full uptake of these guidelines in all hospitals. In response, over the course of 2018, HIQA observed an improvement in screening rates across HSE-run and funded hospitals which has continued into 2019. However, increased awareness and knowledge about multidrug-resistant organisms, such as CPE, are required by all healthcare staff to ensure full compliance with the relevant national guidelines.

During 2018, HIQA noted improvement in national leadership and coordination of the response to CPE. Indeed, the approach taken offers an opportunity for learning in the context of other similar patient safety threats faced by the Irish health service. However, the risks associated with multidrug-resistant organisms, such as CPE, will continue to represent both an existential threat to patient safety in Irish hospitals and a significant operational challenge to the health service into the future. It is essential, therefore, that recent national momentum to address this threat is built upon in order to rise to this challenge, with a particular focus now required on prevention and control of such infections in community settings.

3.2 Medication safety

HIQA's medication safety monitoring programme assesses public acute hospitals in Ireland against the *National Standards for Safer Better Healthcare* to ensure patient safety in relation to the use of medicines.² The programme aims to examine and positively influence the adoption and implementation of evidence-based practice in relation to medication safety in these settings.

To date, HIQA has conducted 54 medication safety inspections since 2016 — 10 of which were carried out in 2018. Four of the 10 inspections in 2018 were re-inspections, undertaken on the basis of risks identified during the first medication safety inspections in 2016 and 2017.

In January 2018, HIQA published a national overview report of the first phase of the medication safety monitoring programme.²⁹ This report presented the collated findings from 34 public acute hospital inspections that had been conducted in 2016 and 2017. This report identified areas of good practice and areas that required improvement, to ensure medication safety systems were effective in protecting patients. A number of recommendations were made focusing on improving medication safety at a local and national level (see Appendix 2).

The programme initially focused on governance arrangements and systems in place to support medication safety. During 2018, the programme was upgraded to also focus on high-risk medications and high-risk situations. HIQA reconvened its Medication Safety Monitoring Programme Advisory Group to support this. The revised programme was developed in 2018 with inspections commencing in 2019. The current approach is outlined in eight lines of enquiry, based on international best practice and research and aligned to the national standards (see Appendix 3).

Background and context

Medication safety has been identified internationally and nationally as a key area for improvement in all healthcare settings.^{30,31,32,33,34,35} The World Health Organization (WHO), in a global initiative launched in 2017, aims to encourage healthcare services to reduce avoidable harm from medications by 50% over the next five years.³⁶ To achieve this aim, it identified three priority areas which are to:

1. improve medication safety at transitions of care^{§§§§}
2. reduce the risk in high-risk situations^{*****}
3. reduce the level of inappropriate polypharmacy.[◇]

While most medication error may not result in harm for patients, where harm does occur, this can often be very serious and on occasion could result in patient death. Some medicine types or classes are known to be more likely to cause severe harm or death should error occur in their use. International literature recommends that hospitals identify high-risk medications[^] and high-risk situations specific to their services and employ risk-reduction strategies[†] to reduce the risks associated with these medications.³⁷

In addition to patient safety concerns, there are also cost implications with medication errors. A recent publication which reviewed medication-related claims from 2011 to 2016 highlighted that errors with many high-risk medications, including general anaesthetics, opioids, penicillin, antithrombotics and local anaesthetics resulted in associated costs of €7.3 million. The median total cost of each claim was €60,991, with median individual damages of €33,858.³⁸

§§§§ The World Health Organization (WHO) defines transitions in care as the various points where a patient moves to, or returns from, a particular physical location or makes contact with a healthcare professional for the purposes of receiving healthcare. This includes transitions between home, hospital, residential care settings and consultations with different healthcare providers in outpatient facilities. See: World Health Organization. *Transitions of Care: Technical Series on Safer Primary Care*. Geneva: World Health Organization; 2016. Available online from <https://apps.who.int>.

***** High-risk situation is a term used by the WHO to describe situations where there is an increased risk of error with medication use.

◇ Polypharmacy: the use of many medications together, commonly five or more.

^ High-risk medications are those that have a higher risk of causing significant injury or harm if they are misused or used in error. High-risk medications may vary between hospitals and healthcare settings, depending on the type of medication used and patients treated. Errors with these medications are not necessarily more common than with other medications, but the consequences can be more devastating.

† Risk-reduction strategies: a term used to describe different ways of dealing with risks. Strategies include risk avoidance, transfer, elimination, sharing and reducing risk to an acceptable level.

Key findings for medication safety

All 10 hospitals inspected in relation to medication safety in 2018 had formalised governance structures in place. This was an improvement in comparison to the findings in 2016–2017 when only 62% of the hospitals inspected had functioning drugs and therapeutics committees. This is encouraging, especially in those hospitals that required a re-inspection, and indicated a degree of national learning as a consequence of HIQA's monitoring efforts in this area. However, it should be noted that in two hospitals, these structures were in the very early stages of development or had only recently been re-established before the HIQA inspection.

The majority of hospitals (seven) had some form of medication safety programme in place, but three still had no formal strategy or plan to direct related improvement activities.^{39,40}

Seven hospitals demonstrated a sustained improvement in medication incident reporting.[#] Significant under-reporting of medication incidents had been found in some hospitals during HIQA's 2016–2017 inspections. However, there was a significant decline in medication incident reporting in two hospitals that needed to be addressed to ensure a culture of reporting is enhanced across all clinical disciplines.

In general, hospitals used risk registers (management documents which assess and record known risks and proposed measures to manage them, eliminate them or reduce them to an acceptable level). However, formal proactive risk assessments based on known medication safety risks that can harm patients — and which have been widely highlighted in research as being beneficial — were not routinely used in most hospitals.^{41,42}

Half of hospitals inspected (five) provided a comprehensive level of clinical pharmacy^{††††} services to most, if not all, clinical units. One hospital provided a service to approximately only half of its wards.

Compared to what was found at the start of HIQA's medication safety monitoring programme, some limited progress was identified during 2018 in relation to medication

[#] A low number of incidents reported do not necessarily mean a low number of incidents happening. Studies have found a positive association between increased incident reporting rates and measures of safety culture, where an increase in incident reporting was indicative of a positive reporting culture within the hospital.

^{††††} Clinical pharmacy service describes the activity of pharmacy teams in ward and clinic settings. The following core activities are involved in providing clinical pharmacy services: prescription monitoring, prescribing advice, optimising therapeutic use of medicines, adverse drug reaction detection and prevention, patient education and counselling, inter-professional education about medicines. It may also involve some or all of the following: medication history taking, medication reconciliation, specialist clinics for example, HIV, clinical audit, protocol and or guideline development. Source: Pharmaceutical Society of Ireland. *Future Pharmacy Practice in Ireland - Meeting Patients' Needs*. Dublin; 2016. Pharmaceutical Society of Ireland.

reconciliation,⁺⁺⁺⁺ with most hospitals inspected providing some level of medication reconciliation. Given the considerable resources and time implications for providing this, some hospitals were conducting medication reconciliation in areas of greater risk and need. Of the 10 hospitals inspected, seven provided medication reconciliation on admission of patients and in wards that had clinical pharmacy services. This was an improvement in comparison to 2016 and 2017 inspections where less than half of hospitals inspected provided some level of medication reconciliation.

Seven hospitals provided the required guidance for staff in relation to medication safety in easy-to-access formats in clinical areas, while all hospitals provided some education to staff, both at induction and on an ongoing basis. Most hospitals used training modules available on HSELand^{§§§§} and provided other in-house training, both formally and on an unplanned and informal basis.

Although the four hospitals re-inspected demonstrated some improvement in 2018, HIQA issued what are termed 'high-risk letters' to all four hospitals due to limited progress made between inspections on specific risks identified. One re-inspected hospital received a high-risk letter specifically related to risks arising from inadequate storage of medications that required refrigeration and risks associated with uncontrolled access to a treatment room in a paediatric area. In the other three re-inspections in 2018, HIQA informed the hospitals of a composite of failings in relation to medication safety, including:

- a lack of clinical pharmacy services
- a lack of locally developed or adapted information to guide clinical staff in the safe use of medications, such as a hospital formulary (a list of approved medicines with guidance for their use by clinical staff) and intravenous medication monographs and
- disparities and limitations in the implementation of quality improvements for medication safety.

The lack of progress made with medication safety in these three hospitals highlighted that improvements require long-term focus and investment.

Opportunities for improvement in medication safety

- It was of concern to HIQA that given the value of providing a clinical pharmacy service, five hospitals inspected during 2018 provided only very limited clinical

⁺⁺⁺⁺ Medication reconciliation is a process of creating and maintaining the most accurate list possible of all medications a person is taking including drug name, dosage, frequency and route. This process identifies any discrepancies and ensures any changes are documented and communicated to complete an accurate medication list.

^{§§§§} HSELand is the Health Service Executive's elearning and development service.

pharmacy services and only allocated resources to functions such as antimicrobial stewardship, oncology and critical care areas.

- HIQA's overview report for medication safety between 2016–2017 recommended that all hospitals should have a defined formulary process in place.²⁹ However, only one of the 10 hospitals inspected in 2018 had a formulary process in place. A second hospital used a preferred medications list detailing medications that were approved for use with some sections updated annually. Three other hospitals demonstrated good evidence that plans were underway to formally establish a process to create a formulary in the hospital.
- Three hospitals were not conducting any formal medication reconciliation. No hospital was routinely conducting medication reconciliation on discharge, which could present a missed opportunity to ensure that patients have the correct medications prescribed when leaving hospital.⁴³ This finding reflects the experience nationally and internationally, despite recommendations and guidelines, that medication reconciliation practices are challenging to perform and poorly implemented.⁴⁴
- Inspectors found some evidence of medication safety audit, but much of this audit activity was not linked to an overall medication strategy. Many audits were neither strategically planned nor coordinated. Hospitals mainly relied on nursing and midwifery care metrics[‡] to monitor aspects of medication management.
- Three hospitals inspected did not provide staff with basic information required to safely administer and prepare medications, such as intravenous monographs or guidelines.
- There was scope to improve the education and training delivered in relation to medication safety in all 10 hospitals inspected.

Conclusions on medication safety monitoring

During 2018, some hospitals were found to have performed well in implementing medication safety programmes. HIQA often found that change and improvement was led by key individuals committed to improving safety for patients who were also well supported by managers and leaders. There was, however, marked and widespread variation in medication safety programme application across all hospitals inspected.

Throughout the medication safety monitoring programme, it was clear that, where there have been dedicated clinical pharmacy resources, medication safety was

[‡] Metrics are measures used for comparison or to track performance. Nursing and midwifery care metrics support quality improvement by providing information about the quality of care. Source: <https://www.ehealthireland.ie/Case%20Studies/Nursing-Midwifery-Quality-Care-Metrics/>.

prioritised and medication safety systems had been well developed using an evidence-based approach. Most modern acute healthcare services deploy clinical pharmacists to work with clinical teams, in order to better tailor medication use for the benefit of patients and to prevent potential harm associated with medication use.^{45,46,47,48,49,50,51}

Some examples of the enhancements demonstrated to HIQA wherever clinical pharmacy services were provided included:

- more direct engagement with patients and clinicians by pharmacists about medication use
- greater levels of medication reconciliation
- increased medication incident reporting.

These findings further support HIQA's previous recommendation that the HSE develop a national plan for providing comprehensive clinical pharmacy services. Such a plan would set out the desired model of care and ensure a nationally consistent approach in clinical pharmacy services across all hospitals.^{29, 52}

Current and future challenges exist in relation to under-reporting of medication incidents in many hospitals. While it is encouraging that most hospitals inspected had increased the number of reported incidents, it was still predominantly nurses and pharmacists who reported medication safety incidents.

HIQA found some collaboration between hospitals within and across hospital groups in relation to improving medication safety. However, this requires a greater focus at a hospital group and national level in order to reduce duplicated effort and to support greater collective improvement in medication safety.

HIQA found improvements were markedly better in those hospitals that demonstrated that medication safety was a priority. Better and more effective arrangements were generally more evident in the country's voluntary hospitals (those funded, but not run by the HSE). Voluntary hospitals had, in general, invested in and supported innovation in medication safety and clinical pharmacy services to a greater extent than many of those hospitals directly funded and run by the HSE.

2018 was the third year of this medication safety monitoring programme. As such, it was discouraging that the pace of progress with implementing improvement in relation to medication safety has remained slow in some hospitals. It was also evident that medication safety had not benefited from the same level of national coordination and momentum as has been applied in addressing the threat from CPE. This is an unacceptable situation for the patients that depend on and the staff that work within healthcare services. Medication safety now requires greater prioritisation within the HSE, through a more concerted and ambitious long-term national approach, with the

aim of better protecting patients from potential medication errors and the harm associated with them.

4. New programmes commenced or under development in 2018

A significant body of work was conducted by HIQA in 2018 to prepare for future thematic monitoring programmes and an expansion in HIQA's legal remit and functions. New programmes of regulation and monitoring included:

- preparing for the commencement of regulation of medical exposures to ionising radiation
- starting a new programme of monitoring against the *National Standards for Safer Better Maternity Services*, and
- preparing for the start of a new programme of monitoring against the *National Standards for Safer Better Healthcare* in rehabilitation and community inpatient healthcare facilities.

4.1 Regulation of medical exposures to ionising radiation

A medical exposure is when a patient receives ionising radiation as part of their diagnosis or treatment. This can include a simple dental X-ray, a more complex CT or CAT scan and radiotherapy that a patient may receive as part of their cancer treatment.

The International Commission on Radiological Protection's recommendations in 2007 on regulating exposure to ionising radiation was incorporated in the EU Council Basic Safety Standards (BSS) Directive in 2013, which required adaptation into Irish legislation.⁵³ The signing of this legislation into law by the Minister for Health, in January 2019, resulted in HIQA becoming the 'Competent Authority' in Ireland with responsibility for the regulation of medical exposures to ionising radiation.⁵⁴ This work programme is undertaken by HIQA's Healthcare Team.

To support this programme of regulation, HIQA has published several guidance documents for healthcare and dental services, both public and private, outlining reference materials for undertakings⁺ responsible for providing medical exposures. These include:

- assessment-judgment framework for assessment of compliance
- guidance on the assessment of compliance
- guidance for undertakings providing medical exposures
- guidance for undertakings on reporting accidental or unintended exposures.

⁺ Undertakings refer to service providers who are responsible for the conduct of medical exposures.

Preparing for regulation of medical exposures to ionising radiation in 2018

While awaiting the introduction of the relevant regulations, HIQA continued to prepare for the commencement of regulation of medical exposures to ionising radiation in Ireland throughout 2018.

Transposing the European directive into Irish law has seen the Environmental Protection Agency (EPA) retain responsibility for regulating occupational and environmental exposure to radiation. During 2018, HIQA and the EPA continued to work closely to ensure seamless and efficient regulation in their respective areas of statutory responsibilities. Formal communications between both agencies were also strengthened with the signing of a data sharing agreement in December 2017.

During 2018, other organisations previously involved in patient radiation protection assisted HIQA's Healthcare Team in its preparations for its new regulatory role. HIQA liaised with the National Radiation Safety Committee (NRSC) and the HSE's Medical Exposure Radiation Unit (MERU) throughout the year, to ensure that knowledge and experience was not lost during the transfer of responsibilities. HIQA wishes to recognise and acknowledge the assistance of both bodies in aiding with this transition of function.

HIQA has also continued to liaise with the Department of Health on matters relating to the transposition of the EU Directive into Irish law.

Because the Irish radiation protection regulations have their origins in European law, HIQA attended meetings and workshops of the Heads of European Radiological Protection Competent Authorities (HERCA) in 2017 and 2018, as observers. This provided an invaluable insight into how different European regulators work together in order to identify common issues and propose practical solutions for these issues.

HIQA has also identified the need for a panel of experts to advise it on key competent authority functions assigned to HIQA in the Irish regulations. An Expert Advisory Group was set up in 2017 for this purpose, which comprised representatives from the Irish Association of Physicists in Medicine, the Irish Institute of Radiographers and Radiation Therapists, the Faculty of Radiology and the Irish Dental Association, amongst others.

The Advisory Group met in November 2017 and was in agreement with HIQA to adopt the HSE's Medical Exposure Radiation Unit's existing incident reporting thresholds of significant events[±] notifiable to HIQA by services providing medical ionising radiation — with some slight amendments. This was proposed to ensure continuity in reporting during the transition from regulation by the Medical Exposure Radiation Unit to HIQA.

[±] Significant events are instances of accidental and unintended exposures deemed to be of sufficient risk that they need to be reported to the regulator.

As a result of this consultation, in early 2019, HIQA published guidance on radiation incident notifications to HIQA.

4.2 Monitoring against the *National Standards for Safer Better Maternity Services*

In 2018, HIQA commenced a new programme of monitoring maternity hospitals and maternity units in public acute hospitals. This programme aims to assess whether maternity services have the essential elements in place to provide safe and effective care, in line with the implementation of the *National Standards for Safer Better Maternity*⁴ services, with a particular focus on obstetric emergencies.

This monitoring programme covers all 19 maternity units and maternity hospitals in the Republic of Ireland. For the purposes of the monitoring programme, obstetric emergencies are defined as pregnancy-related conditions that can present an immediate threat to the wellbeing of the woman and baby in pregnancy or around the time of birth.

Background and context

Under the Health Act 2007 (as amended), part of HIQA's role is to set standards in relation to the quality and safety of healthcare and to monitor compliance with these standards. The *National Standards for Safer Better Maternity Services*⁴ were published by HIQA in December 2016. These national standards were developed using the same framework as the *National Standards for Safer Better Healthcare*,² which were launched by HIQA in 2012.

The maternity standards support the implementation of the National Maternity Strategy, which was launched by the Minister of Health in January 2016. These standards, when implemented, aim to support consistently safer, higher-quality maternity services. The implementation of national standards helps to set public, provider and professional expectations and enables service providers to consistently provide safe, high-quality care.

HIQA started the design and development of this monitoring programme in early 2018. An expert advisory group was formed to advise HIQA on the development of the monitoring programme and its methodology. This group met on three occasions in 2018 and membership included clinicians, managers and people with expertise in the areas of midwifery, obstetrics and gynaecology, neonatology, surgery, perinatal epidemiology, anaesthesia, critical care, management and patient advocacy.

In monitoring against the national standards, with a focus on obstetric emergencies, HIQA identified three specific lines of enquiry (the questions to be asked) in monitoring maternity services. These lines of enquiry represent what is expected of a service

providing a consistently safe, high-quality maternity service, particularly in its response to obstetric emergencies. The lines of enquiry have been used by HIQA to identify key relevant national standards for assessment during this monitoring programme. Further information may be found in HIQA's *Guide to maternity standards monitoring programme – revised 2019*,⁶ which is available online at www.hiqa.ie.

The monitoring programme also examined progress made across the maternity services to develop maternity networks. The national standards support the development of maternity networks in Ireland. On 30 May 2018, all 19 maternity units and maternity hospitals were asked to complete a comprehensive self-assessment questionnaire which was developed by HIQA.

In August 2018, HIQA began two-day unannounced inspections in maternity services across the country. Five inspections were completed by the end of 2018, with the remainder of the 19 services scheduled to be inspected in 2019. During these inspections, inspectors used specifically developed observation and interview tools. Inspections were also used to validate some of the self-assessment findings submitted by the services themselves.

On completion of the on-site fieldwork for this monitoring programme in 2019, a national overview report, along with the individual inspection report for each maternity hospital and or maternity unit, will be published on www.hiqa.ie.

4.3 Monitoring of rehabilitation and community inpatient healthcare services

In 2017 and 2018, HIQA identified a number of community and rehabilitation hospitals and facilities that provided healthcare services across the country which were not registered, regulated or monitored by HIQA. HIQA undertook announced on-site visits to these identified facilities to determine whether these organisations were providing healthcare services or met criteria to be designated centres for residential care under the Health Act 2007 (as amended) and were, therefore, eligible for registration.

The project which commenced in 2017 is set out below in three phases:

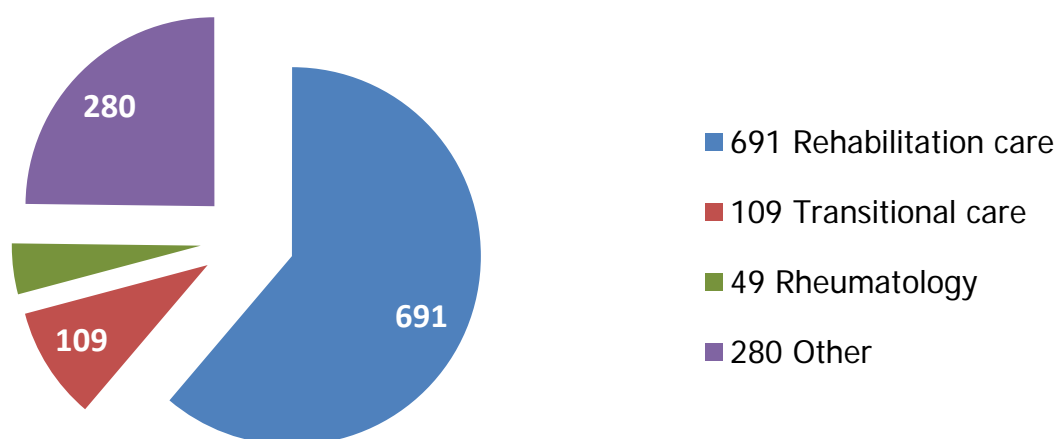
- **Phase 1** — A request for details from the relevant HSE national directors was made to identify all hospitals and facilities within their area of responsibility which were not designated centres and not monitored by HIQA.
- **Phase 2** — Each identified facility completed and submitted a self-assessment questionnaire to HIQA.
- **Phase 3** — An announced HIQA on-site visit was conducted to validate the information provided in the self-assessment questionnaire.

As a result of this process, HIQA identified 23 inpatient hospitals and or facilities (with 1,129 beds) that provided rehabilitation and community inpatient healthcare services and which were funded or managed by the HSE. Following the on-site visits, HIQA identified that:

- Five services were under the governance of existing public acute hospitals. HIQA determined that these services would be included in HIQA's existing thematic inspections of public acute hospitals.
- Five voluntary services had what is termed 'section 38[#] service-level agreements' with HSE community health organisations. HIQA determined that these services will be monitored under the Rehabilitation and Community Inpatient Healthcare Services programme of inspection.
- Thirteen services were under the governance of HSE community health organisations. A number of different models of care were identified from the self-assessment questionnaire, which included rehabilitation, step-down services, transitional care, respite services, convalescence services, patient assessment services and palliative care services. HIQA determined that these services will be monitored under the Rehabilitation and Community Inpatient Healthcare Services programme of inspection.

The type of care provided is illustrated in Figure 2 below.

Figure 2. Types of care provided in the 1,129 beds identified by HIQA in 2017 and 2018 not regulated or monitored by HIQA



[#] Private and voluntary providers receive funding from the HSE through what are commonly referred to as 'section 38 arrangements'. This is a reference to section 38 of the Health Act 2004 which allows the HSE to fund organisations to provide services on its behalf. Services are also funded in this way under section 39 of the Health Act 2004.

Brief profile of publicly-funded rehabilitation and community inpatient healthcare services

Rehabilitation and community inpatient healthcare services provide an important tier of specialised step-down and or rehabilitative care. Through its announced visits in 2018 and information provided by these services, HIQA found a diverse range of healthcare being provided to patients in these services.

For example, some facilities provide more advanced nursing care skills such as cannulation,^{*****} administration of intravenous therapy and or enteral feeding^{†††††} with a focus on avoiding a re-admission to an acute hospital. Other facilities provided basic nursing care, with patients being transferred back to acute hospitals if they became unwell.

The majority of patients were being provided with multidisciplinary care to enable their recovery or rehabilitation following an admission to acute hospital services. Patients had discharge plans in place and most patients expected to be discharged to their own homes. The average length of stay across these services ranged from just six days in to over 90 days for those patients requiring complex rehabilitative care.

Future plans

As part of its 2019 Business Plan, HIQA will commence a programme of monitoring and inspection of rehabilitation and community inpatient healthcare services against the *National Standards for Safer Better Healthcare*. The programme will focus on governance and risk management structures, measures to ensure the prevention and control of healthcare-associated infections and the safe use of medicines.

Unannounced inspections under this new programme will start later in 2019. Guidance on the inspection process for providers and the public has been published on the HIQA website www.hiqa.ie.⁵⁵

^{*****} Cannulation means the placement of a hollow plastic tube called a 'peripheral venous cannula' into the vascular system (veins). Peripheral venous cannulation allows the administration of fluids, drugs, blood products and nutrition through the veins.

^{†††††} Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum (part of the small intestine just below a person's stomach) or jejunum (also part of the small intestine).

5. Looking forward – key strategic challenges in healthcare in Ireland, impending reforms and HIQA's future role

The Health Act 2007, as currently amended, defines HIQA's role in the healthcare setting as that of monitoring against national standards in public hospitals. Monitoring against standards is intended to promote improvement by healthcare providers, who are expected to work towards meeting the standards.

HIQA is aware, through multiple monitoring programmes and other sources of information, that hospitals are working to comply with the standards in an ever-changing and increasingly challenging environment. Furthermore, this environment looks set to change considerably from a legal and policy perspective over the coming years.

This chapter outlines what the public has told us about their experience of the health system, the key underlying challenges that the healthcare system faces as seen through HIQA's monitoring programmes, and the likely intended changes to the role of HIQA's powers under planned legislation.

5.1 What the public told us

HIQA receives information on what healthcare services are like from a number of sources. The National Care Experience Programme is a joint initiative from HIQA, the HSE and the Department of Health.⁺⁺⁺⁺⁺ Through various surveys, it asks people about their experiences of care in order to improve the quality of health and social care services in Ireland. This initiative provides vital information to the Healthcare Team and is used as part of its monitoring programmes.

Members of the public, patients, relatives and staff members working in healthcare organisations can also contact HIQA directly and provide information and feedback about health or social care services. Feedback is received by HIQA's dedicated Concerns Team who provide advice and guidance as required and pass all information received to the Healthcare Team for further review.

For more information, see HIQA's booklet, *We want to hear from you: How to provide feedback or make a complaint about a health service*, which is available on our website: <https://www.hiqa.ie/reports-and-publications/guide/how-provide-feedback-or-make-complaint-about-health-service>.

In 2018, HIQA received 343 pieces of unsolicited information about identified healthcare services. All relevant information received is recorded, reviewed, risk rated

⁺⁺⁺⁺⁺ Visit <https://yourexperience.ie/> for more information.

and linked to national standards so that this information can be tracked and trended both collectively and individually. When required, HIQA engages with healthcare providers and takes the necessary action to seek assurance in relation to specific cases and risks brought to its attention.

The majority of the standards cross-referenced to the information received were aligned to the themes of person-centred care (40%), safe care (26%) and effective care (23%). The main standards referenced were standard 3.1 (24%), standard 1.8 (15%), standard 1.7 (13%) and standard 2.6 (9%) as detailed below.

National Standards for Safer Better Healthcare

- **Standard 3.1:** Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.
- **Standard 1.8:** Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.
- **Standard 1.7:** Service providers promote a culture of kindness, consideration and respect.
- **Standard 2.6:** Care is provided through a model of service designed to deliver high quality, safe and reliable healthcare.

This information is reviewed by inspectors to identify trends or patterns that indicate unacceptable care and ensure that healthcare services meet the essential standards of care. Unsolicited information about identified services is used to inform HIQA's thematic monitoring programmes and is reviewed before hospital inspections.

The information received through the people who contact us and the National Care Experience Programme highlight the challenges that exist within the healthcare system and how it affects individual patients and families on a daily basis. These challenges are also observed through our monitoring programmes as outlined in the next section.

5.2 Underlying challenges in the healthcare system as seen through HIQA's monitoring programmes in 2018

Through its various means of monitoring the health service against national standards, HIQA has witnessed the numerous challenges that the healthcare system in Ireland continues to face. These include:

- continued difficulties within the HSE of providing services within allocated budgets

- increasing demand for healthcare due to an ageing population and a range of new treatment options⁵⁶
- increasing complexity of service needs, as a result of new treatment options, in combination with a rapid growth of long-term illnesses rather than short-term emergency illnesses, in particular in the frail elderly population⁵⁷
- the ongoing model of care dominated by acute hospital care
- capacity deficits⁵⁸ and
- difficulties in filling key front-line jobs in the health service.^{59,60,61,62}

Many of these challenges reflect the experiences of other healthcare systems internationally. However, other challenges are more specific to Ireland. In particular, the Irish public healthcare system is characterised by difficulties in accessing timely treatment in many instances.

In the context of international shortages of healthcare professionals, Ireland faces continued challenges in building up and maintaining its front-line healthcare workforce. Throughout HIQA's monitoring work in 2018, this issue was seen more often in smaller hospitals outside of the main urban areas, and in certain specialties.

A situation of continued concern to HIQA in 2018, prompting ongoing escalation to senior HSE management, was the practice of filling some consultant posts by doctors who do not hold specialist registration with the Medical Council in Ireland. This reflects a 2018 judgment by the High Court which ruled that this practice infringes the HSE's policy that all new consultant posts must be filled by a doctor on the specialist register.⁶³

Following engagement with the HSE in 2018, better mechanisms to ensure senior HSE managerial oversight of this concern were developed, as well as formalised mechanisms for clinical governance of non-specialist registered doctors employed as consultants. Further efforts will be necessary to ensure the resolution of this ongoing risk.

It is important to note that despite the challenging environment, some of which are outlined above, results from the 2018 National Patient Experience Survey shows that patients who use the health service generally reported positive levels of satisfaction from a patient experience perspective.

In addition, internationally-benchmarked outcome-measures for certain clinical situations often compare favourably with other countries. For example, data collected by the Organisation for Economic Co-operation and Development (OECD) highlights that Ireland has better health outcomes when compared with the OECD average in specific areas such as stroke and heart attack in-hospital mortality. In contrast, caesarean section rates and hospitalisation rate for chronic obstructive pulmonary

disease (COPD) require improvement when rates are compared to other OECD countries.⁶⁴

When patients are able to access services, for the most part these services tend to be of a good clinical standard insofar as reliable international comparison allows. However, it is recognised that challenges exist with access to healthcare services and the system requires significant reform.

5.3 Reforms to address challenges within health services

In response to challenges within the health service, the Oireachtas Committee on the Future of Healthcare^{§§§§§§} worked in 2017 to develop a strategy called *Sláintecare*. This strategy is aimed at navigating the Irish healthcare system through these challenges over the following decade.¹ The *Sláintecare* report outlines the need to re-orientate services away from the prevailing hospital-dominated model of care to a more community-based model.

In addition, the Department of Health's capacity review identified a need for 1,260 extra beds in the acute hospital system to meet current demand (assuming inpatient bed occupancy was reduced to 85%).⁵⁸ By 2031, it found that requirements could potentially grow by 5,360–7,150 beds (an increase of between 40.2% and 53.7% on the accessed capacity in 2016).

Furthermore, a number of additional key strategic policy documents in the areas of maternity care⁶⁵ and trauma care⁶⁶ have been published in recent years. If implemented fully, both strategies look set to have significant implications for the way health services and acute hospitals are configured nationally in the years to come.

HIQA is fully supportive of both the *Sláintecare* vision for the Irish health service, and the need for reconfiguration of services as set out by policy-makers through other key documents also described above. Indeed, HIQA believes that such reforms are long overdue – with the current problems experienced within the health service only likely to worsen further unless such changes are advanced.

HIQA intends to play its part in supporting this transition. Indeed, future additional legislative changes of direct relevance to revising HIQA's role and remit look set to further contribute to and advance this agenda. The following section of this report provides a brief overview of what these future changes may involve based upon currently available information.

^{§§§§§§} The Committee on the Future of Healthcare was established by Dáil Éireann in 2016 with the goal of achieving cross-party, political agreement on the future direction of the health service, and devising a 10-year plan for reform. *Sláintecare* sets out the intention to develop and adopt such a 10-year plan for health services to deliver required changes. See <https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/> for more information.

5.4 Recent and future planned legislative changes of direct relevance to HIQA's role and function

Proposed changes outlined in the 2016 Programme for Government envisage an expanded and revised role and function for HIQA in the oversight of healthcare services. These changes will arise from two similar sounding, but distinct, pieces of new legislation that are currently under development. These changes are in addition to the new role that HIQA has recently assumed, in line with European legislation, to regulate medical exposures to ionising radiation.

The Patient Safety Bill

Despite the fact that approximately one-fifth of acute healthcare services in Ireland (and a greater proportion of elective acute services) are conducted in private hospitals, HIQA has not had a remit for monitoring these services to date.

In July 2018, the General Scheme of the Patient Safety Bill was approved by the Government and was referred to the Oireachtas Health Committee for consideration.⁶⁷ The Bill provides for the mandatory open disclosure of serious patient safety incidents to those who have been harmed by them. The Patient Safety Bill also provides for reportable incidents to be notified to HIQA and extends HIQA's current remit for monitoring against national standards to private healthcare services.

This will mean a significant expansion of HIQA's role to include private facilities providing certain defined healthcare activities. Currently, HIQA monitors national standards under defined programmes in 50 public acute hospitals and 23 public rehabilitation and community inpatient healthcare services. It also monitors medical ionising radiation services in public and private healthcare and dental services.

It should be noted, however, that this intended legislation does not provide HIQA with enforcement powers. The Sláintecare implementation plan intends for this legislation to be signed into law in the latter part of 2019. In the interim, HIQA continues to prepare for this legislation.

The Patient Safety (Licensing) Bill

Future additional legislative changes in relation to how healthcare is regulated, such as through the further proposed Patient Safety (Licensing) Bill, will see a significant change in HIQA's function. The legislation envisages that HIQA's role will include the licensing of services across the public and private healthcare sector, with the provision of enforcement powers to HIQA to support it in bringing healthcare providers into compliance if necessary.

In June 2018, HIQA attended, and had the opportunity to make a submission to, the Oireachtas Joint Committee on Health regarding this proposed bill. Throughout 2018,

HIQA was in close liaison with the Department of Health in contemplation of both the licensing legislation and the Patient Safety Bill. At the time of writing this report, HIQA continues to engage with the Department of Health in relation to the drafting of this legislation.

Regulation of medical exposure to ionising radiation – our initial work

Since commencement of this new role, HIQA has worked to provide key interested parties and undertakings with information on HIQA's approach to regulation. In conjunction with the publication of key guidance documents, a series of information events have been held around the country as a means of sharing information between the regulated community and HIQA.

Later in 2019, HIQA plans to issue a self-assessment questionnaire to individual undertakings to assess their baseline level of compliance with the regulations. This self-assessment questionnaire will serve as an improvement tool for each undertaking, as it allows any risks or gaps in practice to be identified. HIQA will use this self-declared information to inform a risk-based programme of inspections for medical exposure to ionising radiation in the latter part of 2019.

This approach will take into account the potential magnitude and nature of the risk associated with different practices; for example, an acute hospital and a dental setting, while also generally assessing radiation protection issues and their level of compliance with these regulations.

5.5 Concluding comment

In conclusion, HIQA is aware of the many challenges that currently exist within the healthcare system as told to us by patients and as seen through our thematic monitoring programmes. Changes envisaged under new legislation proposed will bring significant change for both HIQA and healthcare providers alike. It is HIQA's intention to fully engage with all stakeholders, including those who will be monitored or inspected under new legislation, in advance of any new developments.

6. Overall conclusion

HIQA is very aware that the healthcare services that it monitors face significant challenges. Sláintecare¹, the blueprint for restructuring and reforming the health service, is an opportunity to provide healthcare in Ireland in a way that reflects the aims and ambitions of the national standards produced by HIQA. When implemented fully, this significant reform will fundamentally impact healthcare services and change the way services are delivered. Conscious of these developments, HIQA will continue to ensure its monitoring programmes are aligned to national policy and the long-term strategy for reform and improvement in healthcare services.

Within this context, and despite the well-documented challenges that the Irish health service continues to work to address, HIQA continues to find examples of excellent care which meet and exceed the national standards, delivered by committed and highly capable people. This often conflicts with other areas within the health service inspected by HIQA that struggle to sustainably achieve high standards of care.

During 2018, HIQA focused its resources on known areas of risk through thematic monitoring programmes in public acute hospitals, and worked to develop a number of new programmes. These programmes support continual improvement in those services inspected. This work in 2018 was aimed at ensuring that HIQA's monitoring programmes supported sustained improvement and ensured that the focus of each programme was where it needed to be.

Findings in 2018 identified some tangible improvements in preventing and controlling healthcare-associated infections, particularly in the management of the significant threat posed by CPE. Preventing and controlling healthcare-associated infections is an area that HIQA has been monitoring since its inception in 2007, and it serves to highlight that improvements in addressing such risk requires time, focus and impetus at a national level. The sense of urgency and national drive in relation to CPE should now be shared and replicated in other areas that are known to harm or potentially harm patients.

Some hospitals have also demonstrated a clear commitment to continually improving their approach to ensuring medication safety over a long period of time, recognising that there are always opportunities for further improvement. In the better performing hospitals seen in 2018, HIQA often found that the drive for change and improvement was led by key individuals committed to improving safety for patients. Notably, these individuals were also well supported by managers and leaders, and this enabled and facilitated improvement and ensured that essential services, such as clinical pharmacy support, were in place.

Because of its near universal impact on patients, medication safety must be better prioritised in Irish public acute hospitals in the future. This area of care warrants urgent

and more ambitious attention at a national level within the HSE, equivalent to the approach taken with prevention and control of healthcare-associated infection. This will require work to enhance a heightened culture of medication safety, combined with system improvement based on evidence and supported by technology to protect patients.

Boosting medication safety in public acute hospitals will also likely require further targeted investment. International evidence shows an improvement in safety represents a strong financial incentive for such investment. Notwithstanding this, HIQA has also found that more can often be done within existing resources to improve local organisation and oversight of medication safety systems. However, this remains a work in progress in many Irish hospitals.

While an analysis of the collective findings for 2018 from HIQA's monitoring programmes identifies some improvement, perennial issues emerge year-on-year in the country's acute hospitals, such as overcrowding, which continue to raise concerns. Recent policy developments and commitments to address these issues are important developments. In the interim, while waiting for the implementation of policy developments, the Irish health service will continue to face significant challenges.

HIQA is aware that its work impacts on a wide range of informed and interested parties, which include patients, members of the public, service providers and relevant Government departments. Legislative changes planned will modify and expand the role of HIQA. The next number of years will be a time of transition for both healthcare services and for HIQA in adapting to these changes. HIQA commits to ensuring that these changes are fully communicated to providers, funders, and people using health services in an open and transparent way.

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8. Appendices

Appendix 1 – HIQA inspections of public acute hospitals, 2018

Hospital		Type of inspection	Inspection announced or unannounced
1.	Midland Regional Hospital, Tullamore	PCHCAI	Unannounced
2.	Portiuncula Hospital, Ballinasloe	PCHCAI	Unannounced
3.	Cappagh National Orthopaedic Hospital	PCHCAI	Unannounced
4.	St Vincent's University Hospital	PCHCAI	Unannounced
5.	Royal Victoria Eye and Ear Hospital	PCHCAI	Unannounced
6.	St James's Hospital	PCHCAI	Unannounced
7.	Midland Regional Hospital, Portlaoise	PCHCAI	Unannounced
8.	Tallaght University Hospital	PCHCAI	Unannounced
9.	Kilcreene Orthopaedic Hospital	PCHCAI	Unannounced
10.	University Hospital Galway	PCHCAI	Unannounced
11.	Mayo University Hospital	PCHCAI	Unannounced
12.	Children's Health Ireland (CHI) at Crumlin (previously known as Our Lady's Children's Hospital, Crumlin)	PCHCAI	Unannounced
13.	St Columcille's Hospital, Loughlinstown	PCHCAI	Unannounced
14.	Our Lady of Lourdes Hospital, Drogheda	PCHCAI	Unannounced
15.	Croom Hospital	PCHCAI	Unannounced
16.	Mallow General Hospital	PCHCAI	Unannounced
17.	Cork University Hospital	PCHCAI	Unannounced

Hospital		Type of inspection	Inspection announced or unannounced
18.	Naas General Hospital	RMD	Unannounced
19.	Connolly Hospital	RMD	Unannounced
20.	St. Michael's Hospital	RMD	Unannounced
21.	Ennis General Hospital	RMD	Unannounced
22.	Roscommon University Hospital	RMD	Unannounced
23.	Mercy University Hospital	RMD	Unannounced
24.	Wexford General Hospital	Medication Safety	Announced
25.	St. John's Hospital	Medication Safety	Announced
26.	University Hospital Waterford	Medication Safety	Announced
27.	Our Lady's Hospital, Navan	Medication Safety	Announced
28.	Midland Regional Hospital, Mullingar	Medication Safety	Announced
29.	University Hospital Limerick	Medication Safety	Announced
30.	Children's Health Ireland (CHI) at Temple Street (previously known as Temple Street Children's University Hospital)	Medication Safety	Announced
31.	Cork University Hospital	Medication Safety	Announced
32.	Letterkenny University Hospital	Medication Safety	Announced

Hospital		Type of inspection	Inspection announced or unannounced
33.	Beaumont Hospital	Medication Safety	Announced
34.	The Coombe Women and Infants University Hospital	Maternity	Unannounced
35.	University Hospital Galway	Maternity	Unannounced
36.	St. Luke's General Hospital, Kilkenny	Maternity	Unannounced
37.	University Hospital Kerry	Maternity	Unannounced
38.	University Maternity Hospital Limerick	Maternity	Unannounced

Note: PCHCAI = prevention and control of healthcare-associated infections.

RMD= reusable medical devices.

Appendix 2 – Recommendations from the HIQA overview report on its 2016–2017 medication safety monitoring programme in public acute hospitals

National recommendations focused on improving medication safety

1. **At a national level, efforts to enhance learning from medication incidents and quality improvement initiatives should be put in place. This should include reviewing research in relation to medication safety, both nationally and internationally, to proactively address medication-related risk.**
2. **Centralised arrangements should be put in place to ensure good practices that HIQA has reported through these series of inspection are shared.**
3. **A national plan for the development of comprehensive clinical pharmacy services that sets out the desired model of care, and the appropriate resources to ensure consistency across hospitals should be developed.**
4. **Develop a national approach to advance medication reconciliation to include defining responsibility for medication reconciliation and using electronic solutions to reduce time spent by clinical staff on medication reconciliation.**
5. **Utilise information technologies such as ePrescribing, smart pump technology and decision support tools to reduce medication incidents and risks. At a national level, hospital groups should work together to commence the implementation of electronic solutions to improve medication safety.**

Recommendations focused on improving medication safety in hospitals

6. **Hospitals must have formalised governance structures with clear accountability and responsibility arrangements to support medication safety. This includes a functioning Drugs and Therapeutic Committee with clear terms of reference and membership to provide assurance that medication management systems are safe.**
7. **The Drugs and Therapeutics Committee should have a clear strategic plan for improving medication safety outlining short-, medium- and long-term goals, with a supporting time-bound medication safety programme or plan.**
8. **Hospitals should have a defined formulary process to outline medicines that are approved for use in the hospital, and provide information and standard guidance on the use of these medicines.**
9. **Hospitals should build patient education requirements into the medication**

management process, based on services provided and their patient population, to ensure patients and or care givers are given the appropriate medicines-related information.

10. Hospitals should provide clinical staff with easily accessible information and or policies, procedures, guidelines and or protocols to guide the safe use of medicines at the point of prescribing, preparation and administration.

11. Hospitals should support a culture of reporting medication related incidents and near misses among all healthcare professionals. Data from medication incidents should be routinely analysed to identify trends or patterns in relation to risk and identify areas that require targeted improvement.

12. Hospitals must ensure healthcare professionals have the necessary competencies to deliver high-quality medication safety through induction and ongoing training. This should include a structured, targeted programme of education for medication safety aligned with the hospitals' medication safety strategy.

Appendix 3 – Medication safety lines of enquiry

Area to be explored	Lines of enquiry	Dimensions and key areas	National standards
Leadership, governance and management	Patient safety is enhanced through an effective medication safety programme underpinned by formalised governance structures and clear accountability arrangements.	Capacity and capability	3.7, 5.1, 5.2, 5.5, 5.4, 5.6, 5.11
Risk management	There are arrangements in place to proactively identify, report and manage risk related to medication safety throughout the hospital.	Quality and Safety	3.1,3.2,3.3, 3.6, 5.8, 5.11, 8.1
High-risk medications	Hospitals implement appropriate safety measures for high-risk medications that reflect national and international evidence to protect patients from the risk of harm.	Quality and Safety	2.1, 3.1
Person-centred care and support	There is a person-centred approach to safe and effective medication use to ensure patients obtain the best possible outcomes from their medications.	Quality and Safety	1.1, 1.5, 3.1, 2.2, 2.3
Model of service and systems for medication management	The model of service and systems in place for medication management are designed to maximise safety and ensure patients' healthcare needs are met.	Quality and Safety	2.1, 2.2, 2.3, 2.6, 2.7, 3.1,3.3, 5.11, 8.1
Use of information	Essential information on the safe use of medications is readily available in a user-friendly format and is adhered to when prescribing, dispensing and administering medications.	Quality and Safety	2.1, 2.5, 8.1

Area to be explored	Lines of enquiry	Dimensions and key areas	National standards
Monitoring and evaluation	Hospitals systematically monitor the arrangements in place for medication safety to identify and act on opportunities to continually improve medication.	Quality and Safety	2.8, 5.8
Education and training	Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff.	Capacity and capability	6.2, 6.3



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