Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF HEALTHCARE SERVICES 2021–2023

December 2023

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, Equality, Disability, Integration and Youth, 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.

Contents

A message from the Director of Healthcare Regulation

Sean Egan, Director of Healthcare Regulation

I am pleased to introduce our overview report for 2021-2023. This report outlines our work to support health and social care services over the last three years. During this time period, the health service continued to respond to the COVID-19 pandemic, and also sought to address the other healthcare needs of the Irish population - the provision of which was often greatly disrupted by the pandemic.

Over this time period, HIQA introduced a new approach to inspection against the *National Standards for Safer Better Healthcare,* focusing on hospitals and emergency departments throughout the country. This has enabled us to report overall compliance levels against these standards across services nationally. In December 2022, we published an overview report which related to the monitoring of health services against the *National Standards for Safer Better Healthcare* using this new approach. That report took a particular focus on conditions in our emergency departments. In the aftermath of the more acute phases of the pandemic, our emergency departments have become ever increasingly overcrowded.

Since the 2022 overview report, further inspection using the same methods has occurred in both emergency departments and more generally across hospitals. The following report provides an additional dataset to inform HIQA's evaluation of service performance against the national standards, and builds upon the work that was outlined in our 2022 overview report which focussed on emergency departments. This report also further supports the view that once patients transition from emergency departments into inpatient beds, their experiences and the conditions within which care is provided often improves.

Our findings further validate the recommendations we made in 2022 to improve services in emergency departments. Significantly, we also found that crowding in

emergency departments should not be considered inevitable. Our findings demonstrated this in a limited number of hospitals where capacity, management, whole health-system engagement and adequate workforce provision were addressed. These hospitals serve as a good example of how overcrowding in emergency departments can be avoided, with focused effort on the necessary improvement measures. Indeed, this report contains examples of how escalation of concerns by HIQA within the HSE, followed by targeted intervention and investment and repeated follow-up by HIQA, has begun to yield improvements for patients.

The health service has seen an important expansion in workforce numbers over recent years. Despite this, HIQA's monitoring work continues to identify that at the frontline, ongoing deficits to required staffing complements may be found in some services – especially those services provided in more geographically-remote hospitals. This results in a reliance on agency or overtime cover, and can impact of patient safety and continuity of care. A key lesson that should be taken from the pandemic is that our healthcare workforce represents a critical strategic asset within the State. Efforts to sustain and support this workforce to meet current and projected future needs should represent a key concern for all involved in both providing and using our health services into the future.

In terms of HIQA's regulatory function in medical exposure to ionising radiation, overall compliance findings with core regulations has improved year on year from 2021-2023. This is a positive finding and demonstrated that service providers are working towards improving compliance with the regulations.

As I look to the future, I'm pleased that we have the opportunity to ensure safer care and better services as HIQA moves into new areas, including;

- Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
- Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Bill 2022
- Monitoring of International Protection Accommodation Services (IPAS - formerly referred to as direct provision) through engagement with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).

While HIQA is preparing for future expansion of our remit under pending legislation, the Irish health system is also adapting as we emerge from the acute phase of the COVID-19 pandemic. On 5 May 2023, the World Health Organization declared that the global public health emergency phase of the pandemic had ended. While COVID-19 will continue to pose significant direct challenges for the health system in managing the ongoing burden of disease that it poses, the indirect impact of the

pandemic on the health system is now also becoming more evident. This includes the impact of deferred or delayed care for patients, the impact of the understandable need to divert attention away from ongoing necessary reforms in the health service to address the immediate risks posed by the pandemic, and also the toll that the pandemic and its aftermath has had on healthcare staff. Findings from HIQA's work as described in this overview report for the periods 2021-2023 should be considered in this context.

Finally, I want to again reflect on the critical role that staff working in the health system play. Between 2021 and 2023 in particular, healthcare staff faced significant challenges under extremely difficult circumstances in adapting and maintaining services where possible for patients. During the course of our inspection work, my team meet with many staff and patients providing and receiving care across the health service. In our engagement with patients, there is near universal praise for the work that healthcare staff perform at the frontline. Our inspectors also acknowledge that the healthcare workforce has experienced a level of stress and trauma posed by the pandemic that – with some exceptions - is uncommon related to the general wider workforce in Ireland. Furthermore, the Irish population is growing and aging at pace. Ever-increasing demands on this workforce posed by a continued need to catch up with deferred care, allied to an aging and growing population, mean that demands placed upon them will continue to grow. Efforts to sustain and support this workforce will be critical in ensuring that the health service that we all aspire to - and that the *National Standards for Safer Better Healthcare* aim to promote - are developed and maintained into the future.

Sean Egan

Director of Healthcare Regulation

Health Information and Quality Authority

1. Introduction

Under Section 8 of The Health Act 2007, as amended, HIQA has a responsibility to monitor compliance with the *National Standards for Safer Better Healthcare* in publically-funded healthcare services.[1] HIQA also has a remit to conduct statutory reviews or investigations into services where there are potential serious patient safety concerns impacting on the health and welfare of patients. In addition, HIQA is the competent authority in Ireland with responsibility for regulating medical exposure[i] to ionising radiation.[2]

The report outlines the substantial body of work undertaken over this period to revise HIQA's approach to monitoring against the *National Standards for Safer Better Healthcare*. This overview report also summarises the key findings from HIQA's monitoring of healthcare services in Ireland over the years 2021-2023. In particular, this report builds on the early observations and findings in HIQA inspections of emergency departments, of which an overview report was published in December 2022.

This overview report also includes a summary of the review of gynaecology services at Letterkenny University Hospital in 2021. This review was conducted to assess improvements arising from concerns identified relating to the effectiveness of governance and oversight of gynaecology services at the hospital, and an update on progress identified at the hospital in this area since HIQA's review.[3]

Key findings are also outlined from HIQA's programme of inspection of services carrying out medical exposure to ionising radiation. This continued in both the medical and dental sectors, inclusive of the self-assessment of compliance in the dental sector. Findings from the dental sector have been presented in this report, including examples of where good practice was evident on inspection and where areas for improvement were identified. This report also summarises activities from statutory functions under HIQA's remit as the national competent authority for medical exposure to ionising radiation.

[i] Medical exposure to ionising radiation means a radiation exposure received by patients or other individuals as part of their own medical or dental diagnosis or treatment such as X-rays, radiotherapy and so on.

2. The revised approach to monitoring against the *National Standards for Safer Better Healthcare*

2.1 Background

In 2021, HIQA revised its approach to monitoring against the *National Standards for Safer Better Healthcare*. This decision was taken in an effort to build upon our prior work which had focused mainly on thematic areas of know patient safety risk, and to increase our flexibility to monitor compliance in the context of our expanding role. It was also made in contemplation of HIQA's extended role in the monitoring of services and receipt of mandatory notifications as intended under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

A core set of 11 of the 45 standards drawn from five of the eight themes were selected to underpin this monitoring programme (see Appendix 1). These themes include:

- leadership, governance and management (formalised governance, effective management and systematic monitoring arrangements)
- workforce (planning, organisation and management of the workforce)
- person-centred care and support (privacy, dignity, autonomy, kindness, consideration and respect, complaints management and communication)
- effective care and support (in relation to the physical environment and to monitoring, evaluation and continuous improvement)
- safe care and support (protecting service users from harm and effectively managing patient-safety incidents).

This revised approach to monitoring applied learning from HIQA's prior work in thematic monitoring. It was also informed by a process of benchmarking against similar healthcare systems regulators internationally, and by consideration of emerging trends in the areas of patient safety, both nationally and internationally. Furthermore, HIQA took into consideration national policy priorities for quality and safety in healthcare, including the outputs of the National Clinical Effectiveness Committee. HIQA's prior approach to monitoring of healthcare services had more recently been through thematic monitoring programmes, such as infection prevention and control, antimicrobial stewardship, nutrition and hydration and maternity care.

Table 1. Monitoring approaches used in HIQA healthcare inspections and investigations

Proactive	Reactive	Combination
Thematic e.g Infection Prevention and Control, Medication safety etc.	Section 9 investigations	Governance/Assurance Reviews

In order to build on the monitoring programmes to date, HIQA established a programme of monitoring services through the lens of four key areas of known risk in healthcare. The four key areas of risk evaluated under the revised approach include:

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

The importance of incorporating the patient's experience when judging compliance with national standards has been addressed in the new programme by more extensively including the voice of service users as part of the inspection process, while also drawing upon validated information from the National Care Experience Programme[iv] and local hospital findings. This new monitoring programme has enabled HIQA to:

- increase flexibility for monitoring compliance
- adapt to the new and expanded role with the implementation of the Patient Safety (Notifiable Incidents and open Disclosure) Act 2023, Human Tissue

[ii]The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

[iii] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available online from: https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

[iv] The National Care Experience Programme (NCEP) is joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health.

(Transplantation, Post-Mortem, Anatomical Examination And Public Display) Bill 2022, Sláintecare and other changes

- facilitate a model of inspection that will help prepare for healthcare licensing.

The services that are currently under HIQA's inspection remit include 89 public acute hospitals, and community and rehabilitation inpatient hospitals. The new inspection approach involves a minimum of two inspections in each hospital in a three-year cycle, to include one announced and one unannounced inspection. In instances where HIQA becomes aware of a specific risk within a service, a targeted risk-based inspection may be carried out against any of the 45 national standards as appropriate.

In addition to current services under the remit of healthcare monitoring, prospective legislative changes in relation to licensing, the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, and the Human Tissue (Transplantation, Post-Mortem, Anatomical Examination And Public Display) Bill 2022, place a need to prepare for a more extensive monitoring programme across an increased number of settings, including the private sector.

A guide to the assessment judgment framework providing additional advice and examples of lines of enquiry (questions) on use of the assessment judgment framework in respect of all 45 standards was prepared and published in April 2022.[4] A further 12-page summary, titled *Monitoring Approach against the National Standards for Safer Better Healthcare* was also published in April 2022.[5]

2.2 Development of fieldwork tools for the revised monitoring programme

An assessment judgment framework for all 45 standards was developed to guide this programme of monitoring using HIQA's common 'Authority Monitoring Approach' [v] to ensure consistency in carrying out HIQA's functions as required by the Health Act 2007 (as amended).

The purpose of the assessment judgment framework is to support HIQA inspectors in gathering evidence when monitoring or assessing a service, and to make judgments on compliance. The framework sets out examples of the lines of enquiry to be explored (questions to be asked). The framework provides transparency for service providers and the public on how HIQA assesses and makes judgments about compliance against the national standards, ensures that healthcare services are

[v]The Authority Monitoring Approach (AMA) is HIQA's collective term for the processes and procedures that support the work of the regulation directorates in the areas of fieldwork and escalation.

treated fairly, and that the assessment of compliance against the national standards is timely, consistent and responsive to any risks identified within services.

The framework also outlines the judgment compliance levels, which we term 'compliance descriptors' as outlined in Table 2.

Table 2. Judgment compliance descriptors used by HIQA in healthcare inspections

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

2.3 Rollout of revised programme of monitoring

The new programme was originally intended for launch in 2021, but was delayed by the various waves of the COVID-19 global pandemic and by the cyber-attack on the HSE ICT infrastructure. However, stakeholder engagement with the HSE and Department of Health in relation to the programme progressed in late 2021 and continued into 2022.

In April 2022, HIQA commenced the new monitoring programme of inspections in healthcare services against the *National Standards for Safer Better Healthcare*. Monitoring using the revised programme began with four pilot inspections undertaken in model[vi] 2, 3 and 4 hospitals, and a rehabilitation and community

[vi]Model of hospital informs the level of service provided at the hospital e.g model 1 (community/district hospital), Model 2 and Model 3 (general hospital) and Model 4 (tertiary referral hospital),

inpatient hospital service. Following these pilot inspections, the methodology was further refined and enhanced incorporating feedback from the service providers inspected. In 2023, HIQA published additional documents on the HIQA website to further support its monitoring approach. This included;

- A guide to healthcare inspections against the *National Standards for Safer Better Healthcare*.[6]
- Sample self-assessment questionnaires to assist services to self-appraise performance against core standards from the *National Standards for Safer Better Healthcare*.[7]

The list of services inspected by HIQA in 2022 and 2023 under this new programme is listed in Appendix 2.

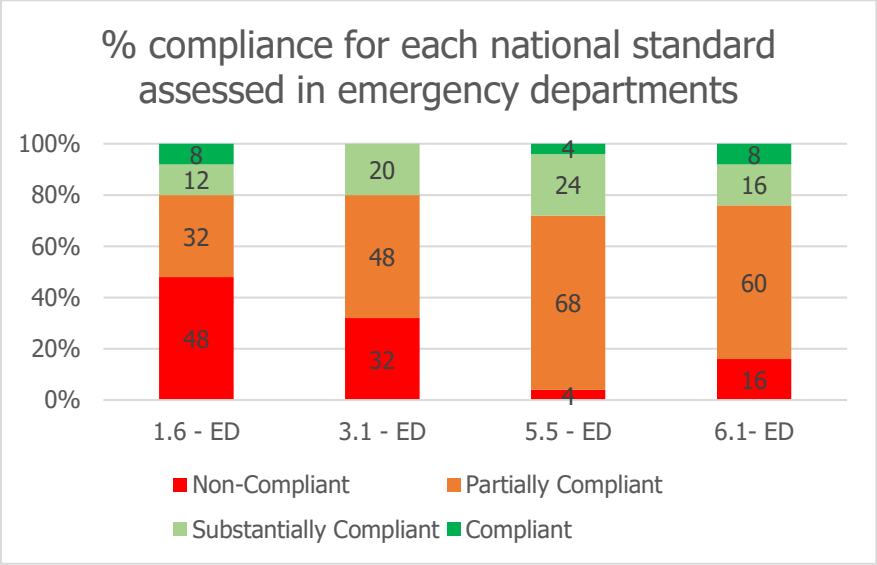
3. Inspection findings related to emergency departments under the *National Standards for Safer Better Healthcare*

In December 2022, HIQA published an overview report of its monitoring programme against the national standards in emergency departments in 2022.[8] That report presented HIQA's initial findings from the first seven emergency departments inspected as part of HIQA's new monitoring programme in 2022. This report builds upon that overview report, and contains findings from the additional emergency departments inspected in 2022 and 2023, as part of emergency department centred or whole-hospital inspections[vii]. The composite of the findings of those additional inspections has allowed HIQA to develop a broader view of the differing levels of performance experienced in emergency departments, and also builds upon what we reported on in the 2022 overview report. A table of compliance judgements from each emergency department inspected is included in Appendix 3.

As was found in HIQA's 2022 overview report, many emergency departments inspected in 2022 and 2023 were over capacity on the day of inspection, with intended emergency department capacity occupied by admitted patients awaiting an inpatient bed. Insufficient patient flow impacted patient experience times[viii] (PET) in respect to the HSE's six, nine and 24-hour PET targets. This resulted in only 28% of hospitals inspected demonstrating compliance or substantial compliance for effective management arrangements.

[vii] Pilot inspections conducted in 2022 and inspection reports in draft are not included in compliance data considered in this report.
[viii] Percentage of all attendees at ED who are discharged or admitted within six, nine and 24 hours of registration. Total Emergency Department Time (TEDT) is measured from registration time to ED Departure Time.

Table 3. Percentage compliance by each national standard assessed in emergency departments



While some hospitals were found to be compliant or substantially compliant with standard 1.6 in respect of person-centred care and support, the environment and circumstances in which patients were cared for in 80% of these emergency departments were found to be ineffective in respecting and promoting the dignity, privacy and autonomy of patients using the service.

All hospitals were able to describe their intended systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. However, HIQA found that these systems were not always effective in protecting patients from the risk of harm, particularly in the context of overcrowding. Only 20% of hospitals inspected demonstrated substantial or full compliance with this standard. Issues impacting patient flow were similar to those outlined in the 2022 report. This included increased ED attendances, lack of community services resulting in delayed transfers of care and higher medical average length of stay. In some situations, hospitals also cited a reduction in the necessary level of access to GPs in the community as impacting on higher ED attendances. Higher presentation levels for services users over 75 years, and lack of access to child and adolescent mental health service were also cites as impacting ED attendance numbers.

Shortfalls in staffing proved to be another issue, with shortfalls seen when compared to the approved whole-time equivalent posts in place. Four hospitals were found to be non-compliant against this standard after significant shortfalls in medical and nursing staff were identified. Similar to hospitals in the HIQA 2022 overview report, hospitals were often reliant on agency staff, and hospital staff were working

additional shifts or redeployments to maintain both the nursing and NCHD rosters. The unfilled shifts impacted the quality and safety of care provided to patients in emergency departments. In addition, the attendance at and uptake of mandatory and essential training for nursing staff in the emergency department required improvement in a number of hospitals.

While many instances of partial or non-compliance was seen in 2022 and 2023, the inspections of the emergency departments of Beaumont Hospital and University Hospital Waterford (UHW) demonstrated good overall levels of compliance with the *National Standards for Safer Better Healthcare*. The hospitals had been adequately resourced to provide a good standard of care, and had worked to reduce staff vacancy rates. Both hospitals had a full complement of nursing staff in the emergency departments at the time of inspection, and had established greater availability and access to consultants and senior decision-makers. Both hospitals also had good access to step-down facilities and beds, which facilitated efficient patient flow within and from the hospitals.

Overall, the findings from the emergency departments inspected in 2022 and 2023 concurred, for the most part, with those of the first seven EDs included in the 2022 Overview Report. The four key areas identified for both immediate and longer-term attention to address safety issues in our emergency departments are still as relevant today as they were in 2022. This includes:

- The need to continue to urgently build additional capacity within the whole healthcare system, both acute and community. This will also require associated investment in additional supports to aid infrastructural capacity, inclusive of diagnostic services to support community capacity.
- Responsive leadership at local, regional and national level, that needs to flex when performance or capacity issues are identified. Such an approach should also not only be confined to just acute services. A collective approach to ownership of this problem across both acute and community services in each region is required.
- A more effective approach to strategic workforce planning at local, regional and national level that builds on benchmarking and safe staffing for medical and nursing staffing levels in our emergency departments. In addition, responsive actions are needed to address short-term staffing deficits relative to surges in ED presentations, and use of parameters to measure and improve performance inclusive of timely triage and medical assessment.

However, it is important to note that this was not always the case as seen on inspection. Beaumont Hospital and University Hospital Waterford had managed to

move from a situation of persistent overcrowding in the emergency departments to one where such crowding was well managed or not present. Management at both hospitals had implemented effective operational measures and oversight to support efficient functioning of their emergency departments to reduce overcrowding. A key element in both hospitals had been the increase in available bed capacity both in the hospital and in local step-down facilities – inclusive of those provided in the private sector - to enable patient flow.

4. Inspection findings related to wider hospital and other clinical areas under the *National Standards for Safer Better Healthcare*

This section presents a summary of the overview of findings related to 25 inspections conducted in 2022 and 2023[ix]. A description of how the services performed in relation to compliance with the national standards monitored during those inspections are presented in the following sections under the two dimensions of capacity and capability, and quality and safety. A summary of compliance judgments for individual hospitals is included in Appendix 4. In summary, overall compliance in wards and clinical areas in hospitals visited by inspectors was generally good when compared to findings in the emergency departments inspected. While there were examples of partial and non-compliance seen on inspection, hospitals were found to be fully or substantially compliant for the most part with the national standards assessed.

Capacity and capability of the service

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

Theme 5: Leadership, Governance and Management

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

To deliver high-quality, safe and reliable healthcare, service providers need to have integrated corporate and clinical governance arrangements in place with clearly-defined roles and responsibilities focused on quality and safety outcomes for people who use the service.

As shown in Figure 1, HIQA found that almost 70% of hospitals inspected were compliant or substantially compliant with this standard. These hospitals were found

[ix] Pilot inspections conducted in 2022 and inspection reports in draft are not included in compliance data considered in this report

to have formalised corporate and clinical governance arrangements in place with effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. These hospitals had a focus on quality and safety outcomes for people who used the service with information related to quality and safety outcomes reviewed and monitored by the relevant governing committees.

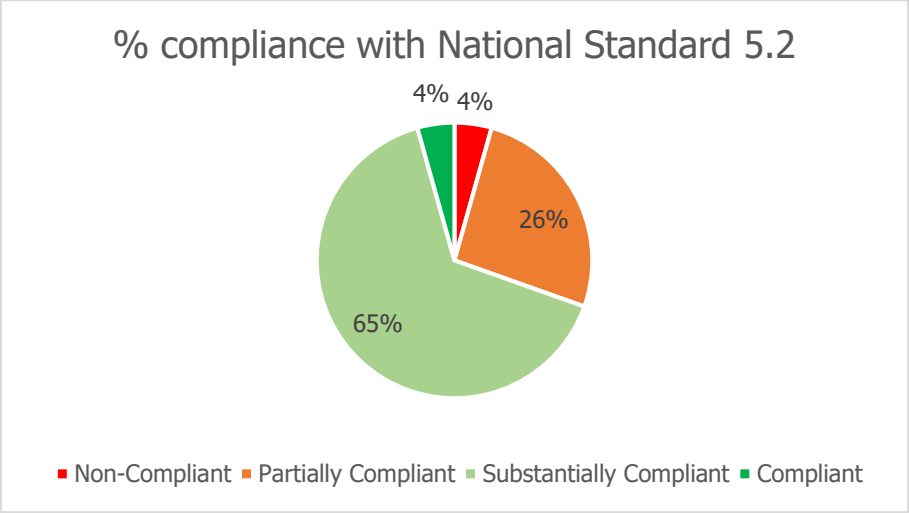
Twenty six percent of hospitals were found to be only partially compliant, as the governance arrangements in place required strengthening to ensure a consistent and effective oversight of the quality and safety of healthcare services at the hospital. University Hospital Kerry was found to be non-compliant as there was limited evidence of the integration of corporate and clinical governance structures and processes in place at this hospital, which had the potential to impact on the clinical and operational effectiveness of that hospital. HIQA sought assurance and information from hospital management that immediate and appropriate measures would be implemented to manage and mitigate any associated risks to patient safety.

All hospitals had Executive Management Teams which were the main governance structure at the hospitals, and had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospitals. All hospitals inspected had multidisciplinary Infection Prevention and Control Committees and governance arrangement in place for the oversight and management of medication safety.

Established Deteriorating Patient Committees to oversee the systems and process in place to anticipate, recognise escalate and respond to the clinically deteriorating patient was progressing in most hospitals inspected. These committees had oversight of the implementation of and the hospital's level of compliance with national guidelines on the relevant Early Warning System[x] and sepsis management.

[x] Irish Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS) Irish Paediatric Early Warning System (PEWS).

Figure 1. Percentage compliance with National Standard 5.2 in the wider hospital inspected including wards



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

HIQA found that hospitals inspected had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services. However, two hospitals did not provide HIQA with assurance of the effectiveness of these arrangements, and HIQA identified opportunities for improvement in many of the other hospitals. Overall compliance data is presented in Figure 2.

Issues with access to diagnostics, especially in relation to radiology diagnostic services, were also identified which impacted on patient care and patient flow in these hospitals. These risks were recorded on the hospital's corporate risk registers with controls and actions in place to manage and reduce recorded risks.

Infection prevention and control

The majority of hospitals inspected had developed an infection prevention and control plan that set out objectives to be achieved in relation to infection prevention and control for the coming year and submitted annual reports outlying progress achieved.

The majority of hospitals had an antimicrobial stewardship (AMS) team who were providing effective governance for the implementation of the hospital's antimicrobial

stewardship programme. Outbreaks of communicable infectious diseases (CID) were well managed in the majority of hospitals inspected in line with national guidance.

Medication safety

While all hospitals inspected had arrangements in place to manage and support the promotion of safe medication management, many hospitals' efforts were impacted by vacancies in pharmacy-staffing level. The availability of a clinical pharmacy service on ward areas, and the undertaking of medication reconciliation for patients on admission and discharge was impacted across a number of hospitals inspected.

Deteriorating patient

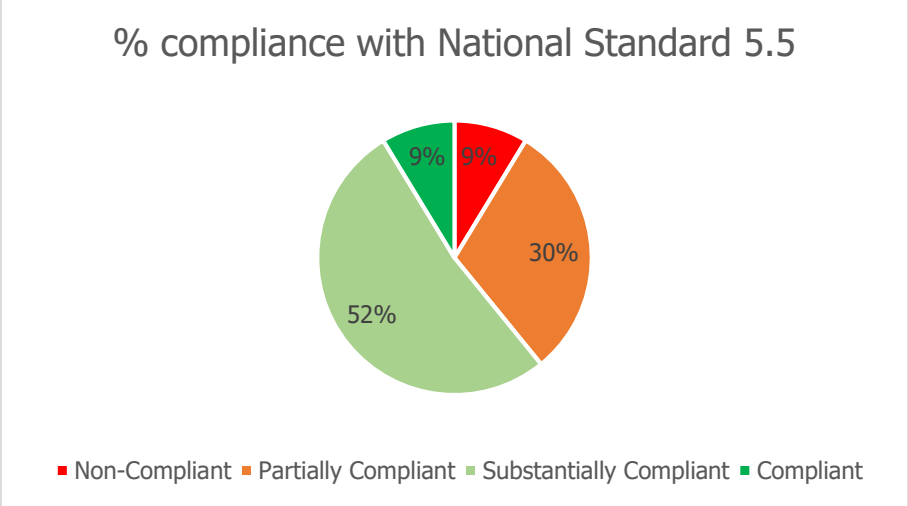
The majority of hospitals had an Early Warning System (EWS) nursing lead who supported and educated staff in recognising and responding to patients that were clinically deteriorating.

Transitions of care

In the majority of hospitals, safe transitions of care for internal transfers, external transfers and patient discharge, was the responsibility of the hospital's Bed or Patient Flow Manager and the Discharge Coordinator. Governance of safe transitions of care was under the hospital's Bed Management or Unscheduled Care Committee.

The majority of hospitals were tracking each patient who had delayed transfer of care (DTOC). The hospitals had processes in place for the oversight and management of patients with DTOC. The main reasons cited by hospitals for patient DTOC related to lack of carers in the community, access to step-down and nursing-home beds and the increasing complexities of patients' needs.

Figure 2. Percentage compliance with National Standard 5.5 in the wider hospital inspected including wards



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

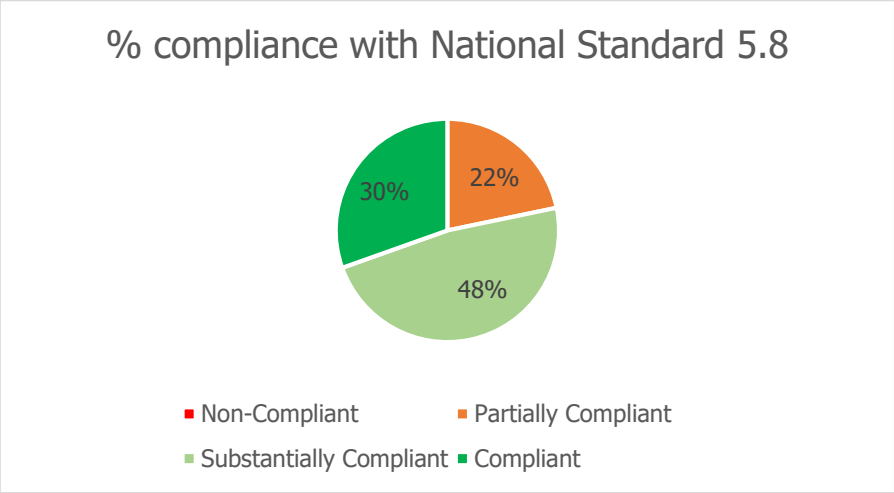
Hospitals require systems to proactively identify, manage, reduce, and eliminate risks to safeguard people who use the service. Hospitals should have systems to document, monitor and analyse patient safety incidents and feedback from people who use the service. Information from monitoring of performance should be used and learning shared to improve the quality and safety of services.

As seen in Figure 3, 78% of hospitals monitored against standard 5.8 were found to be compliant or substantially compliant. These hospitals had effective systematic monitoring arrangements in place at the hospital to identify and act on opportunities to continually improve the quality, safety and reliability of the services provided. These hospitals were monitoring performance against key performance indicators in the area of infection prevention and control and medication safety. However, opportunities for improved monitoring were identified in the areas of the deteriorating patient and transitions of care. Quality improvement initiatives were implemented in response to patient-safety incidents, and monitoring and audit findings. However, a number of hospitals were not compliant with the national target for reporting clinical incidents within 30 days of the date of notification on the National Incident Management System[xi] (NIMS).

The remaining 22% of hospitals were found to be partially compliant with this standard. These hospitals did not provide assurance that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospitals.

[xi] The State Claims Agencies (SCA) National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the SCA (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

Figure 3. Percentage compliance with National Standard 5.8 in the wider hospital inspected including wards



Theme 6: Workforce

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

As seen in Figure 4, 45% of wards and wider clinical areas inspected in hospitals were found to substantially compliant. The remaining 55% were found to be only partially compliant. Many hospitals inspected were working to maintain patient safety on a backdrop of staffing deficits across disciplines when measured against their allocation. Unfilled vacancies and the lack of replacements for short and long-term leave posed challenges for a number of hospitals inspected, impacting on services provided and the organisation's ability to respond to changes in workload.

Medical staff

Many hospitals inspected had unfilled consultant posts. Recruitment to fill these vacant posts was underway in most hospitals, with recruitment at an advanced stage in some hospitals. In some instances, there was an over-reliance on locum consultant staff to support services, which is not a sustainable long-term solution.

Inspectors found in some instances that there were consultants employed in hospitals that were not on the relevant Specialist Division of the Register of the Irish Medical Council. In these hospitals, senior hospital management had provided supports were provided to progress to registration with appropriate oversights in place in line with HSE guidance.

Nursing

There were deficits in the approved nurse staffing levels found in most hospital inspections. In addition to this, additional nursing shortages arose on a daily basis based on short-term need. Staffing deficits and short-term absenteeism did impact on the provision of care, such as one-to-one midwifery support for women in labour.

Some hospitals outlined that the rostered complement of nursing and midwifery staff was only maintained through the use of agency staff or hospital staff working extra shifts. While HIQA acknowledges that senior hospital managements were actively and continuously working to recruit staff, the use of agency or hospital staff doing extra overtime to fill the rosters is not sustainable in the long term.

Medication safety

Many hospitals inspected had unfilled pharmacy positions with one hospital reporting 40% unfilled pharmacist posts. The unfilled posts impacted on the availability of clinical pharmacy services and medication reconciliation services within these hospitals. Recruitment was ongoing to fill vacant posts but proving challenging, especially to fill short term or temporary vacancies.

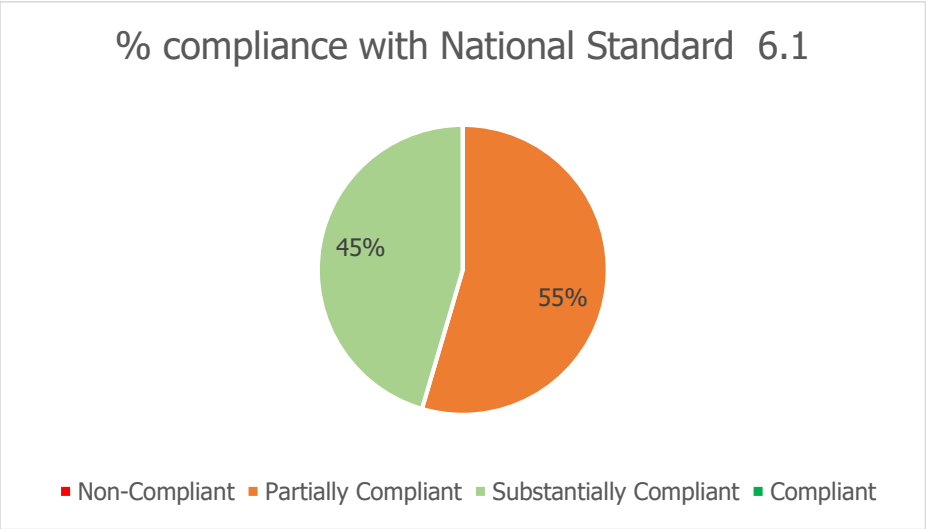
In an effort to mitigate against the risks of pharmacist deficits, one model 3 hospital had looked at ways of expanding the role of pharmacy technicians and fully utilising their skillset. Pharmacy technicians were upskilled to review patients' medication prescriptions and administration records, and flagged issues for review with the clinical pharmacists.

Staff training

Notwithstanding the impact the COVID-19 pandemic had on the delivery, attendance at and uptake of essential and mandatory training over the previous two years, staff attendance at and uptake of training was an area in need of improvement in all hospitals. The oversight of staff attendance at and uptake of mandatory and essential training by senior management required improvement in most hospitals. The majority of hospitals inspected did not have a central process to monitor the uptake of mandatory and essential training at the wider-hospital level, though a number of hospitals outlined that they were working on introducing measures to improve this. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice, and at the required frequency, in line with national standards.

Attendance at essential and mandatory training by non-consultant doctors was recorded on the National Employment Record[xii] (NER) system. Despite this system being in place, NCHD training records were not always available to HIQA. Attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at clinical area level by clinical nurse managers.

Figure 4. Percentage compliance with National Standard 6.1 in the wider hospital inspected including wards



[xii] The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

Quality and safety of the service

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

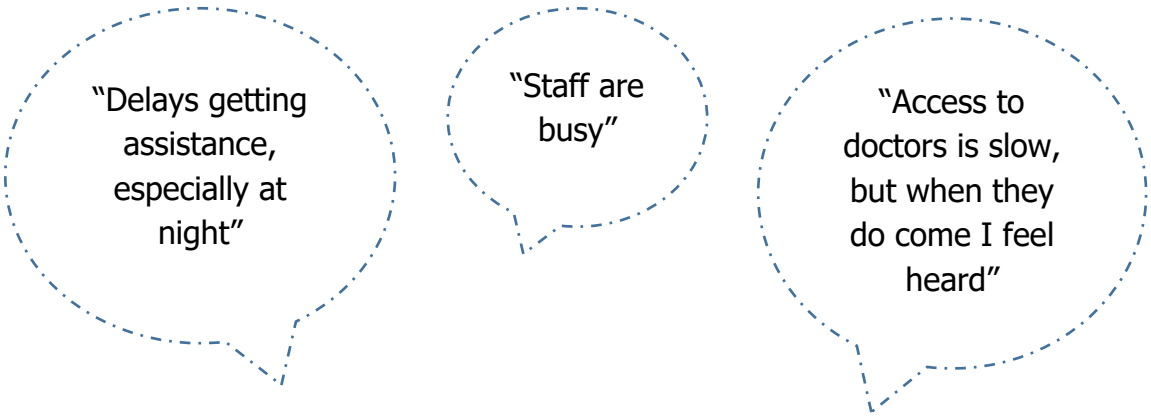
Theme 1: Person-Centred Care and Support

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

People have a right to expect that their dignity, privacy and confidentiality is respected and promoted when attending for emergency care. Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care.

As part of each inspection, inspectors spoke with a sample of patients on the clinical areas about their experience of care. A selection of positive comments from reports are included below.

A selection of areas for improvement is also included from a sample of reports.



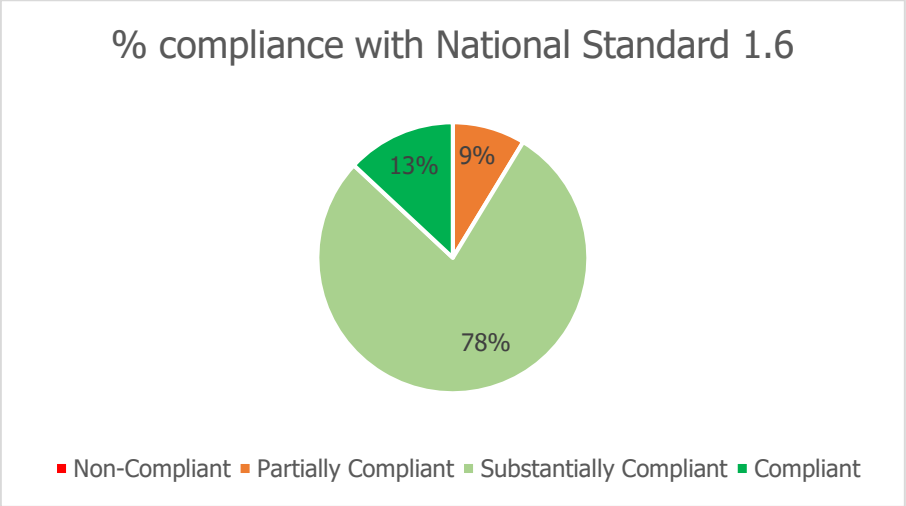
Most patients who spoke with inspectors were not clear on the process of making a complaint, but most patients felt that they could talk to staff if they had any concerns and some commented that they or a family member would go online. Overall, patients were generally positive about their overall experiences when asked.

These findings were consistent with the overall findings from the 2021-2023 National Inpatient Experience Surveys, in relation to the provision of dignity, respect and privacy.

As seen in Figure 5, nine percent of hospitals inspected demonstrated partial compliance with Standard 1.6. In these situations, the limited number of en-suite bathroom facilities in hospitals impacted on the ability to promote and protect a patient's privacy and dignity, especially for those cohorted for infection prevention and control purposes. Opportunities for improvement were identified in relation to the storage and protection of patients' personal information. In addition, the protection and promotion of dignity and privacy for patients was very challenging in hospitals where patients were placed on beds on ward corridors as part of hospitals' full capacity protocol.

However, and in contrast, very positive findings were made in 91% of hospitals which were found to be compliant or substantially compliant with national standard 1.6. There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA.

Figure 5. Percentage compliance with National Standard 1.6 in the wider hospital inspected including wards

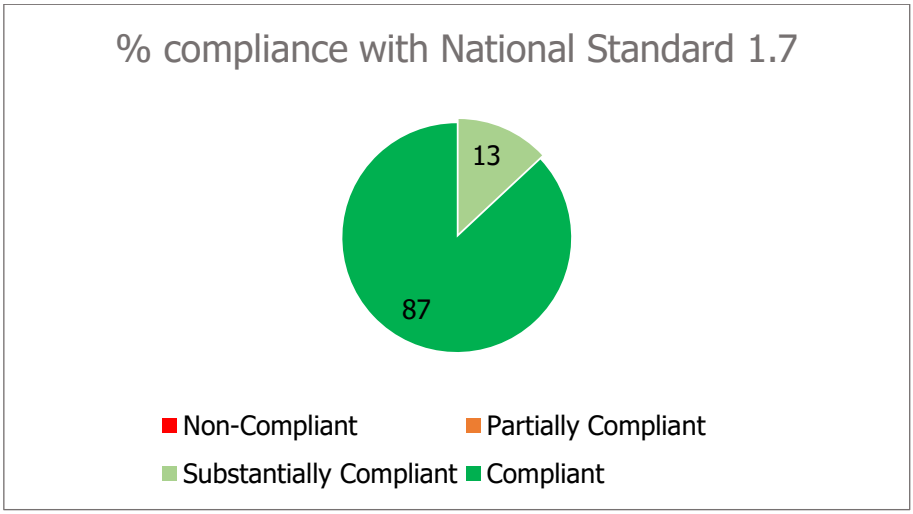


Standard 1.7 Service providers promote a culture of kindness, consideration and respect.

All hospitals were found to be compliant or substantially against this standard and this was echoed in some of the patient feedback under Standard 1.6.

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. However, listening to and acting on patient experiences was an area identified for improvement in three hospital inspected, where patients had raised issues related to their personal comfort which were not acted on.

Figure 6. Percentage compliance with National Standard 1.7 in the wider hospital inspected including wards



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

Inspectors were assured that hospitals inspected had processes in place to respond openly and effectively to complaints and concerns raised by people using the service. As seen in Figure 7, 79% of hospitals were found to be compliant or substantially compliant with this standard.

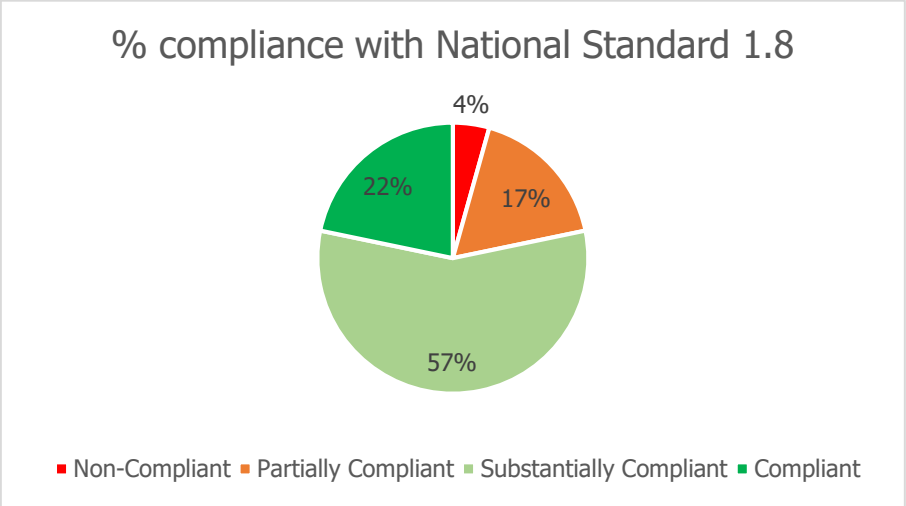
Despite this generally positive set of findings overall, opportunities for improvements were identified in 21% of hospitals to ensure that responses to complaints were sent to the complainant within 30 days, in line with HSE guidance. Some hospitals cited staff deficits within their individual quality and risk departments as the reason for comparatively poor performance with this indicator. Where staff level had increased, an improvement in resolution rates for 2022 was seen. Other hospitals outlined that delays were related to the complexity of complaints, which required a comprehensive coordinated response involving clinical staff.

The majority of hospitals were tracking and trending complaints to identify the emerging themes, categories and departments involved. However, all hospitals did not capture the verbal complaints received at ward level, and this was a missed opportunity for sharing learning and quality improvement. Some hospitals demonstrated evidence of quality improvement initiatives implemented on foot of a service user's complaint. However, inspectors found limited evidence of sharing of

learning from complaints or the complaints resolution process at a wider hospital or hospital-group level, which is an opportunity missed for service improvement.

At the time of inspection, some hospitals had recently appointed a Patient Advocacy and Liaison Service (PALS) coordinator to support patients, their families and carers to provide feedback or make a compliant about the care patients received at the hospital. Advocates ensure that the patient's voice is heard either through the patient directly, or through a nominated representative.

Figure 7. Percentage compliance with National Standard 1.8 in the wider hospital inspected including wards



Theme 2: Effective Care and Support

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

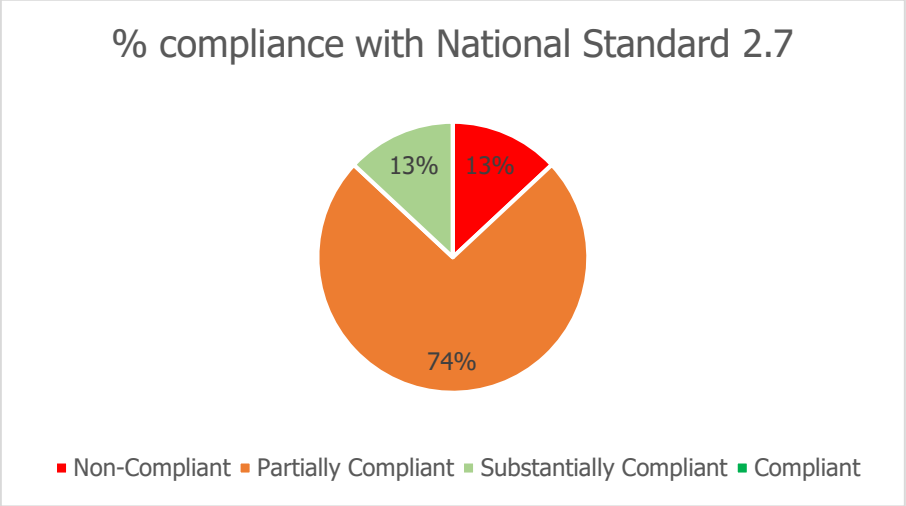
From the inspections in 2022 and 2023, management of hospitals continue to be challenged to deliver a physical environment which fully supports the delivery of high-quality care, and protects the health and welfare of service users. In the context of lessons learned during COVID-19, sufficient single-room capacity and suitable infrastructure to support demand, capacity and limit the possible transmission of infection requires special attention. As seen in Figure 8, none of the hospitals inspected were fully compliant with this standard, with 13% found to be substantially compliant, 74% partially compliant and a further 13% found to be non-compliant. The following opportunities for improvement were identified:

- lack of en-suite facilities in single and multi-occupancy rooms

- hand-hygiene compliant sinks
- general wear and tear of woodwork and floor surfaces, with paintwork and wood finishes chipped, which did not facilitate effective cleaning.

However, during these announced inspections, inspectors observed that overall, in the clinical areas visited, the hospital's physical environment was generally well maintained and clean with few exceptions. Equipment was observed to be generally clean and hospitals had a system in place to identity equipment that had been cleaned, although this systems was not adhered for all hospitals inspected.

Figure 8. Percentage compliance with National Standard 2.7 in the wider hospital inspected including wards



Standard 2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

The majority of hospitals had systems in place to monitor and evaluate the effectiveness of healthcare services. However, there were some gaps identified in audit and monitoring activities across the four areas which were the focus of these inspections. HIQA was not fully assured that all information from monitoring activities was being used to improve practices and that the effectiveness of improvements were being re-audited. Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with standards and guidance, it identifies areas for improvement and provides hospital management, and people who use the service with assurances on the quality and safety of the care and services provided. Overall compliance with this standard is outlined in Figure 9.

Infection prevention and control

Infection Prevention and Control Committees across most hospitals inspected were actively monitoring and evaluating infection prevention and control practices. Monitoring and audit activities including key performance indicators, were reviewed by hospitals' Infection Prevention and Control Committees and reported to and reviewed by the Hospital's Management Team. Evidence of sharing of learning to improve practice was seen across most hospitals.

Medication safety

There was evidence of audit and monitoring of medication safety practices at hospitals inspected. However, while recommendations and actions were identified in medication audits reports, there was opportunity to improve in some hospitals with the development of time-bound action plans to implement these recommendations.

Deteriorating patient

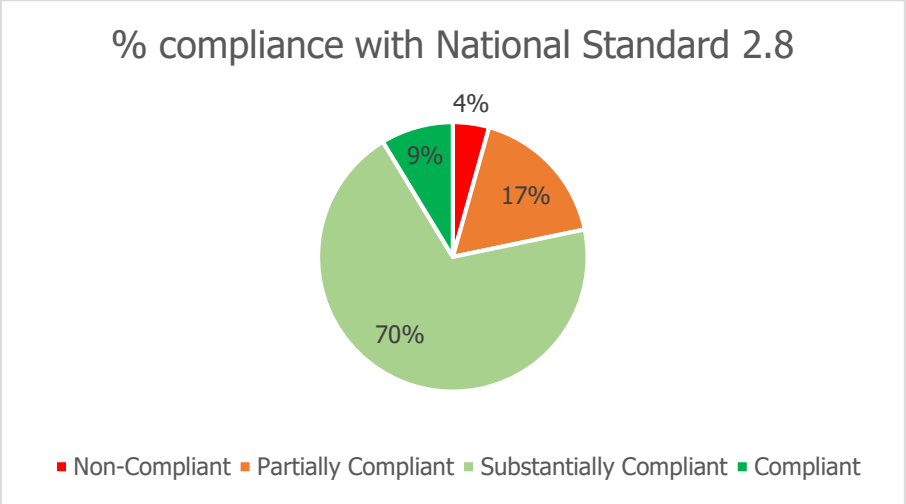
There was opportunity to improve auditing of compliance with national guidance on INEWS and sepsis management, and the ISBAR communication tool for deteriorating patient across hospitals inspected. The majority of hospitals were monitoring compliance against the patient 'monitoring and surveillance' quality care metric.[xiii] However, some hospitals needed to act on monitoring results to improve performance.

Transitions of care

There was opportunity for improvement in both the use of ISBAR[3] for clinical handover and the audit of same in line with national guidance. To ensure that the national clinical handover guideline positively impacts on patient care, it is important that implementation is audited. Audit is recommended to support continuous quality improvement in relation to the implementation of the NCEC guideline. Clinical handover practice should be monitored and audited regularly by healthcare organisations with oversight by governing committees who provide assurance to the CEO or General Manager that the audit is undertaken and any necessary continuous quality improvements are put in place.

[xiii] National Guide for Nursing and Midwifery Quality Care Metrics data measurement Acute Care: 2018. Available online from: HSE National Guideline Nursing and Midwifery Quality Care-Metrics Data Measurement in Acute Care

Figure 9. Percentage compliance with National Standard 2.8 in the wider hospital inspected including wards



Theme 3: Safe Care and Support

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

Quality and safety in healthcare is underpinned by a shared understanding by all of the workforce of the inherent risks which can be reduced by the manner in which services are designed and delivered. A service focused on care and support is continually looking for ways to be more reliable and to improve the quality and safety of services it delivers. All hospitals inspected had structures and processes in place to monitor, manage and escalate risk appropriately. All hospitals inspected were found to have systems in place systems in place to identify and manage potential risk of harm associated with the four areas of harm which were the focus of this inspection - infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, the effectiveness of these systems varied across hospitals.

As seen in Figure 10, 56% of hospitals were judged to be compliant or substantially compliant against this standard. Inspectors found a further 44% of hospitals inspected were only partially compliant, where risk management processes required strengthening in order to provide adequate oversight of potential and actual risks to patient safety identified at the hospital. The areas requiring improvement are included in the following sections.

Infection prevention and control

The demand for single-isolations rooms largely outweighed the available capacity in all hospitals inspected. Many of the available single-isolation rooms did not have en-suite facilities in line with national guidance. This impacted on hospitals' ability to isolate patients with communicable infectious diseases within 24 hours of admission or diagnosis as per national guidance. The lack of isolation facilities was on the corporate risk register of most hospitals inspected and escalated to hospital group level.

All hospitals inspected had policies and procedures in place to screen patients for multi-drug resistance organism (MDROs) such as carbapenemase-producing Enterobacteriaceae (CPE), vancomycin resistant enterococcus (VRE) and methicillin resistant Staphylococcus aureus (MRSA) in line with national guidance. However, not all hospitals were adhering to the hospital's screening policy. For example, the impact of missed CPE screening contributed to CPE outbreaks in Letterkenny University Hospital. This was escalated to Saolta Hospital and a commitment was received from the Chief Executive Officer of Saolta Hospital group to prioritise improvements in relation to these findings. The basis for all control measures is the accurate and timely laboratory identification of bacteria with multidrug resistance. This will deliver important information for the implementation of infection control measures in hospitals. Hospitals need to implement infection prevention and control policies for MDROs and adherence to policies should also be monitored. Control can only be achieved if a national guidance is adhered to by all healthcare facilities.

Medication safety

Risk-reduction strategies for high-risk medicine such as anticoagulants, insulins and opioids were viewed by inspectors on clinical areas inspected and found to be generally aligned with hospital guidance in the majority of hospitals inspected. However, there was some opportunity to implement high-leverage strategies, such as the rationalisation of multiple strengths of infrequently used stock on wards to prevent mis-selection of these high-risk medications. Hospitals had developed a list of sound-alike look-alike medications (SALADs)[xiv] and inspectors observed risk-reduction strategies in place to avoid mis-selection of SALADs.

The availability of a comprehensive clinical pharmacy service is an issue in many hospitals largely due to staffing deficits. A comprehensive clinical pharmacy can reduce the risk of harm to patients by supporting prescription monitoring, clinical

[xiv] SALADS stands for 'Sound-alike look-alike drugs'. The existence of similar drug and medication names is one of the most common causes of medication error and is of concern worldwide. With many drugs on the market, the potential for error due to confusing drug names is significant.

audit, protocol and or guideline development and helping mitigate adverse drug reaction detection and prevention. Inspectors were told that pharmacists would undertake clinical reviews and medication reconciliation for patients with complex, high-risk or multiple medications when requested in clinical areas not provided with a clinical pharmacy service. Pharmacist vacancies and challenges with recruitment of these posts was outlined as the causative factor.

Medicine information to support safe an appropriate prescribing and administration of medicine was available in all hospitals inspected, although in some hospitals this information was only available in electronic format which was not accessible to staff within the clinical rooms where medications were prepared.

Deteriorating patient

All hospitals used the Early Warning Systems appropriate to their cohort of patient to support the recognition and response to the clinical deterioration of patients. The majority of hospitals inspected were using the Irish National Early Warning System (INEWS) V2. University Hospital Kerry had not implemented the INEWS version 2 guideline and observation chart at time of inspection in line with national guidance. The compliance plan submitted by University Hospital Kerry outlined that full implementation of INEWS V2 was to be overseen and audited. The ISBAR communication tool was in use in all hospitals inspected when requesting patient reviews in line with national guidance.

Cavan General Hospital had recently implemented an electronic Irish National Early Warning System which had provided many benefits to identify and respond to the deteriorating patient. For example:

- real-time data collection at point of care
- automated capturing of vital signs and calculation of the early warning score
- clear digital representation of observation charts displayed on portable systems at the bedside and centrally at the nurses station
- access to data for audit and evaluation of the system.

Inspectors noted the considerable potential of the system to be a key support to managing real-time patient data.

Transitions of care

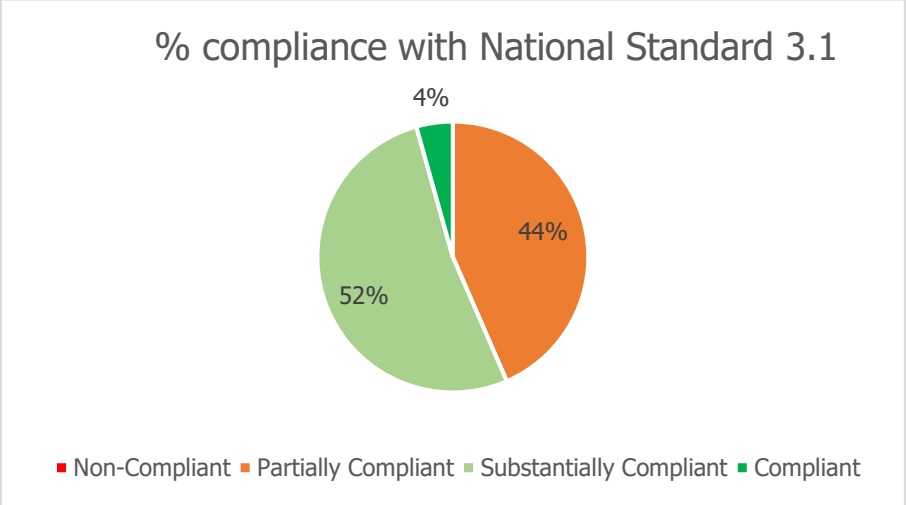
Delays in issuing discharge summaries to primary healthcare services was also identified as an area for improvement. Some, but not all hospitals, had identified this issue through audit and monitoring and had quality improvements in place to

improve compliance. A delay in the standard of communicating with a person's primary healthcare provider at the point of discharge poses a potential risk to their safety and quality of care. The hospitals should ensure that primary healthcare providers have access to timely and up-to-date information on their patients who have been transferred or discharged.

The ISBAR communication tool for interdepartmental and clinical handover was reported as used in six hospital; however, variance in its use was identified by staff and viewed through audit results undertaken by hospitals.

Most hospitals' transfer letter templates had an area to document the patient's infection control status on transfer. However, this section was not always completed on the sample of healthcare records viewed by inspectors and was identified as an area for improvement in hospital audits.

Figure 10. Percentage compliance with National Standard 3.1 in the wider hospital inspected including wards



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

As seen in Figure 11, 83% of hospitals were found to be compliant or substantially compliant against this standard. There was evidence that these hospitals had systems in place to effectively identify, report, manage and respond to patient-safety incidents. These hospitals were tracking and trending infection prevention and control patient-safety incidents and medication incidents, although deteriorating patient and transitions of care were not specific categories where incidents were

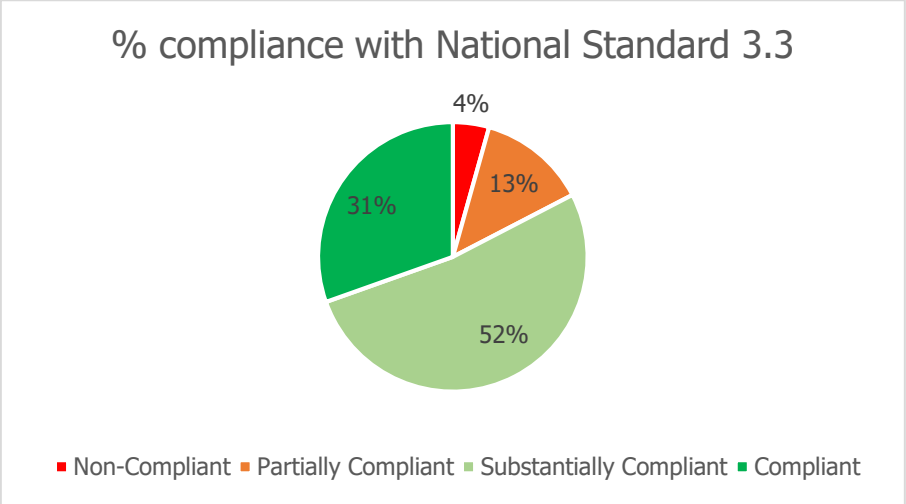
tracked and trended. There was evidence that local governance committees and quality and safety committees had governance and oversight of patient safety incidents. However, some hospitals needed to improve the sharing of learning from patient-safety incidents to reduce the potential recurrence.

HIQA found that 13% of hospitals were only partially compliant with this standard. Opportunities for improvement noted in these hospitals were in relation to the appropriate management and oversight of all incidents, and tracking and trending of patient-safety incidents. Furthermore, quality improvement initiatives arising from the review of patient-safety incidents should be formally documented, implemented and evaluated in line with best practice guidelines in these hospitals. In terms of non- compliance, Letterkenny University Hospital had demonstrated limited evidence that the processes in place to manage and respond to incidents were functioning as effectively as they should, or that sufficient or timely learning was being shared.

All hospitals inspected had a serious incident review team who had oversight and management of category one incidents and serious reportable events which occurred in the hospital. This team was responsible for ensuring that all serious patient safety incidents were managed in line with the HSE's Incident Management Framework. However, in some hospitals inspected, there were delays in implementing the learning and recommendations from serious reportable events and patient-safety incidents and HIQA was concerned about the possible impact this may have on the continual improvement of practice and services for people using these services.

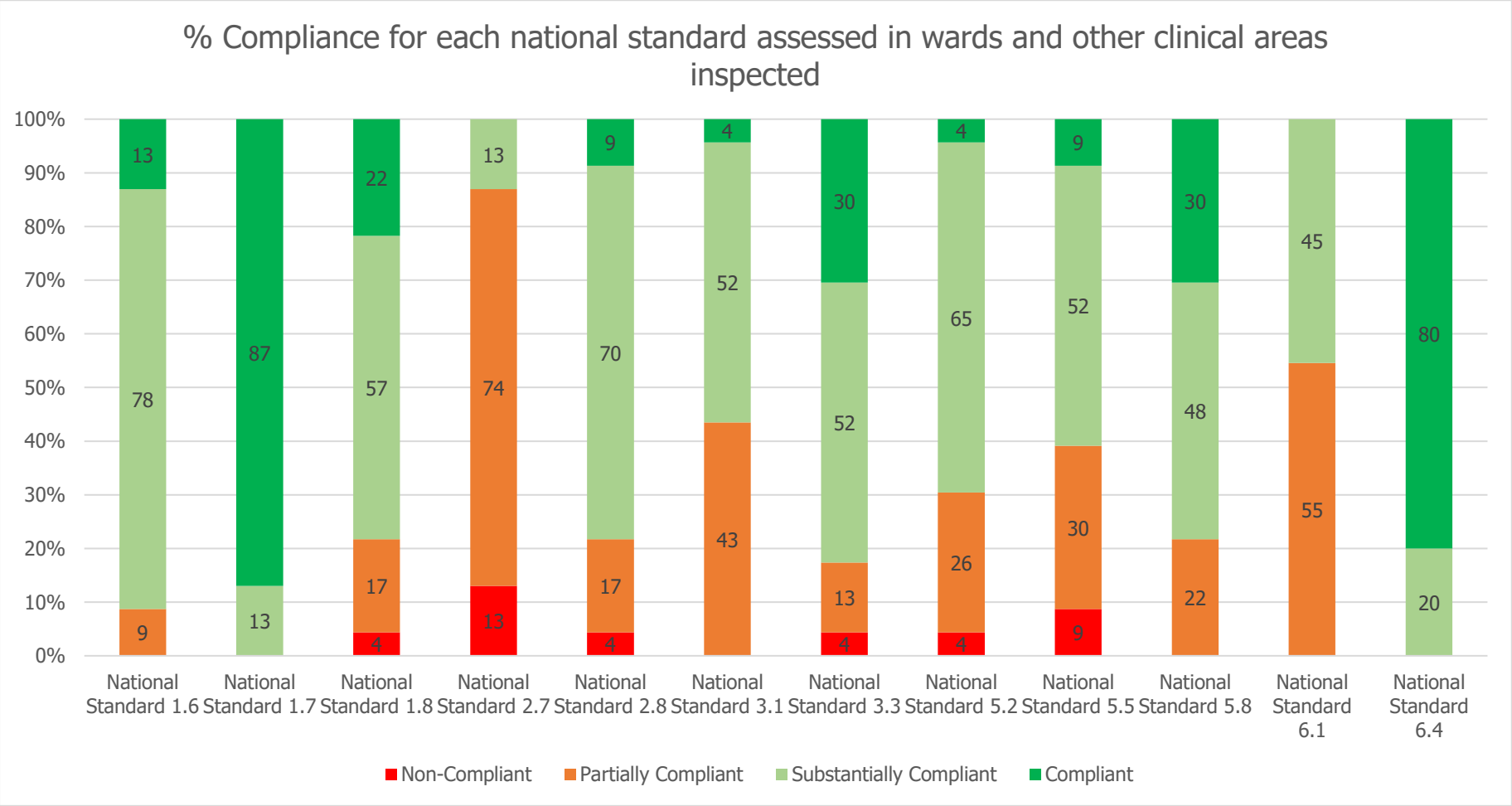
Some hospitals were using the NIMS Electronic Point of Entry (ePOE), a paperless system which facilitated staff to enter incidents directly onto the NIMS. Although at early stage of implementation, the proposed benefits of the ePOE system include the elimination of duplication, availability of real-time data on incidents or near misses and provision of prompts to review and commence risk mitigation processes.

Figure 11. Percentage compliance with National Standard 3.3 in the wider hospital inspected including wards



In summary, as shown in Table 4, compliance in wards and clinical areas was generally quite good when compared to the environments in which patients were receiving care in the emergency departments. This may be partly explained by the controlled number of patients in each ward and the nature of care delivered there when compared to the very busy unscheduled care delivered in emergency departments.

Table 4. Percentage compliance by each national standard assessed in ward and clinical areas other than emergency departments



5. Overall summary of compliance findings against the *National Standards for Safer Better Healthcare* in 2022 and 2023

In April 2022, HIQA commenced a new monitoring programme of inspections in healthcare services against the *National Standards for Safer Better Healthcare*. Findings from this new programme of inspections in 2022 in emergency departments against the national standards continues to highlight that overcrowding in emergency departments compromises the dignity and respect of patients, and poses a risk to the health and safety of patients. While examples of good compliance was seen on occasion, for example, Cavan and Monaghan Hospital, opportunities for improvement were identified across the majority of emergency departments inspected.

As a contrast, overall compliance in wards and clinical areas in hospitals visited by inspectors was generally quite good in 2022 and 2023. While there were examples of partial and non-compliance seen on inspection, hospitals were found to be fully or substantially compliant for the most part with the national standards assessed. While emergency department overcrowding and sometimes insufficient access to acute and primary services are evident in the inspections in 2022, the care that patients receive once admitted to wards is structured and supportive, and this is echoed by the feedback given by patients to inspectors on the days of inspection. There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. Hospitals inspected promoted a culture of kindness, consideration and respect. However, lack of en-suite facilities and patients on beds on ward corridors impacted on staff's ability to meet the patient's personal needs or human rights to dignity and privacy.

The progression of measures within hospital services in relation to infection prevention and control and medication safety building on HIQA's previous thematic inspection programmes is encouraging. Under this new inspection programme, HIQA has expanded its inspection approach to assesses measures to identify deteriorating patient (including sepsis) and escalations where needed, and transitions of care which include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. While it was noted that these are evolving programmes requiring attention in hospitals, and the majority of hospitals provided assurance that the service had systems in place to monitor the effectiveness of healthcare services, there were gaps identified in audit and monitoring activities across the four areas to ensure compliance with targets and adherence to local and national guidance. There were opportunities for improvements in the use of findings from

monitoring activity to drive improvement with re-audit to ensure changes in practice had occurred.

All hospitals inspected were found to have systems in place to identify and manage potential risk of harm associated with the four areas of harm, infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, to ensure that the national clinical handover guideline positively impacts on patient care, it is important that implementation is audited. Clinical handover practice should be monitored and audited regularly by hospitals to provide assurance that the audit is undertaken, and any necessary continuous quality improvements are put in place.

Hospitals provided assurance that they had processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, there was limited evidence of sharing of learning from written and verbal complaints, which was an opportunity missed for service improvement.

In relation to the provision of a physical environment which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of service users, HIQA found that hospitals continue to be challenged by the lack of single-isolation rooms to meet demand for patients that require isolation where needed in line with national guidance. As hospitals continue to provide healthcare in the aftermath of COVID-19, sufficient single-room capacity and suitable infrastructure to support demand, capacity, and limit the possible transmission of infection requires special attention and must continue to be urgently progressed.

Hospitals continue to be challenged to maintain resourcing levels to support the delivery of high-quality healthcare. Difficulties in filling vacancies and replacements for short and long-term absences posed considerable challenges for a number of hospitals inspected. This impacted on the services provided, for example, the availability and use of Acute Medical Assessment Units to support emergency departments. Vacancies particularly affected nursing and medical posts, but also other health and social care professionals providing front-line care, for example pharmacy staffing. The majority of hospitals were not sufficiently resourced to provide a comprehensive clinical pharmacy or medication reconciliation services at care. Oversight and attendance at education and training was an area in need of improvement in all hospitals.

Overall, areas for improvement found particularly relates to patient dignity and privacy, ensuring sufficient workforce numbers, and the protection of patients from harm associated with the design of service delivery. Furthermore, improvements were needed to ensure that there is a responsive approach to the operational management of patient flow, capacity, and appropriate staffing, which reflects

activity within the emergency department. As referenced in the 2022 overview report, while the majority of emergency departments had defined management arrangements in place to address patient flow through the emergency department, the hospital and onwards to the community, these measures were not always effective in ensuring delivery of quality and safe services. All hospitals continue to be challenged with increasing demand, ineffective patient flow, limited surge capacity, and insufficient access to diagnostic services to meet demand. Delayed patient transfers posed challenges for all hospitals inspected. The main reasons cited by hospitals for this related to lack of carers in the community, access to step-down and nursing-home beds and the increasing complexities of patients' needs. However, it must be noted that some hospitals were better able to manage the above challenges. Management at Beaumont Hospital and University Hospital Waterford had implemented effective operational measures and oversight to support efficient functioning of their emergency departments to reduce overcrowding. A key element in both hospitals had been the increase in available bed capacity both in the hospital and in local step-down facilities to enable patient flow. While the geographical and socioeconomic context will differ from hospital to hospital, it demonstrates that good quality care can be achieved.

6. Targeted assurance review of the governance arrangements of gynaecology services at Letterkenny University Hospital in 2021

In addition to the work the HIQA healthcare team were concluding to revise our approach to monitoring against the *National Standards for Safer Better Healthcare*, HIQA also carried out a governance review of gynaecology services at Letterkenny University Hospital during 2021. The following section of this report outlines the background to this review, how HIQA conducted the review, and what was found. It also highlights more recent findings HIQA has identified since 2021 in response to our recommendations.

6.1 Background

HIQA had ongoing concerns about the governance, quality and safety of gynaecology services at Letterkenny University Hospital since 2018. These concerns were forged on the basis of information HIQA had received through our monitoring activities, and also in the context of a number of external reviews commissioned within the HSE to address areas of these concerns following an incident of delayed diagnosis of endometrial cancer.

Over the time period of 2018 – 2021, and in line with its current powers under the Health Act 2007, HIQA engaged with senior management at the hospital, Saolta Group, and nationally in the HSE seeking assurances about the effectiveness of the governance structures and quality and safety of gynaecology services at the hospital. In 2021, HIQA carried out its own review of the governance arrangements at national Health Service Executive (HSE), Saolta University Health Care Group (Saolta Group), and at local hospital level to assure and ensure the quality of gynaecology services at Letterkenny University Hospital.

6.2 Findings of the assurance review of the governance arrangements of gynaecology services

HIQA's review aimed to provide assurance on the effectiveness and sustainability of the governance and oversight arrangements in place at national HSE, Saolta Group and hospital levels to assure and ensure the delivery of high-quality gynaecology services at Letterkenny University Hospital.

HIQA found that the changes and initiatives introduced at the hospital and Saolta Group levels to improve efficiency, quality and safety of gynaecology services at Letterkenny University Hospital had only resulted in some improvements for women referred to the hospital with post-menopausal bleeding at the time of this review in 2021. At the time of HIQA's review, the implementation of the revised governance

structures and accountability arrangements at the hospital and Saolta Group levels had commenced and were in the early stages of implementation.

HIQA concluded this review with the publication of a report, which made a number of recommendations for further improvement of services at the hospital. Overall, HIQA's findings highlighted the shortfalls in the approach to the governance and oversight of gynaecology services at hospital and hospital group levels. It also raised questions about the overall effectiveness and sustainability of the changes and initiatives introduced to improve the efficiency, quality and safety of gynaecology services at the hospital.

In response to HIQA's work in this area, the Saolta Hospital Group committed to implementing corrective actions to address the weaknesses in the governance and quality assurance mechanisms identified by HIQA. This was achieved in part by improving a suite of measures for new referrals to the general gynaecology clinic, reviewing all cases where appointment timelines set by the hospital and national HSE were not met, and auditing of a sample of healthcare records of all women who attend the gynaecology services to ensure compliance with timelines and key performance indicators set by the hospital and national HSE.

In follow up to HIQA's review in 2021, HIQA further engaged with the hospital and Saolta Hospital group in early 2022 to determine progress achieved in implementation of required improvement measures. This exercise identified that the Group was engaged in a plan to address the issues raised in the HIQA review including;

- The ongoing provision of enhanced oversight to ensure the completion of all actions relating to HIQA and other external reviews was underway.
- Enhanced governance and support onsite is continuing at LUH from Saolta University Health Care Group.
- A Change Management programme focussing firstly on vision and mission and then progressing to Governance and Communication had commenced.

6.3 Follow up since the publication of the review

HIQA followed up on the implementation of recommendations from the review and received metrics and performance data relating to both the post-menopausal bleeding clinic and the ambulatory gynaecology service on 18 February 2022 and again on 26 September 2022 respectively.

A follow-up inspection of Letterkenny University Hospital was carried out in November 2022. As part of compliance assessment against the *National Standards*

for Safer Better Healthcare, the inspection team met with the external clinical director supporting the improvements in the gynaecology service and visited the Gynaecology ward. More recently in 2023, further assurances and metrics were received periodically on the service since that inspection, in addition to the final report of the outgoing external clinical director and action plan based on his recommendations to validate this assessment.

HIQA has been since satisfied that this service has seen significant improvements relative to findings identified in 2021. Notwithstanding this identified improvement trajectory, ongoing monitoring of this service will be required to ensure that the improvements are sustained.

The full report of HIQA's review of the governance arrangements of gynaecology services at Letterkenny University Hospital was published in October 2021 and is available at www.hiqa.ie.

7. Regulation of Medical Exposure to Ionising Radiation from 2021-2023

The European Union (Basic Safety Standards for Protection Against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations as amended (referred to in this chapter as the 'regulations') provide a framework for regulating medical exposure to ionising radiation in Ireland. HIQA is the competent authority in Ireland with responsibility for inspecting against and enforcing these regulations.[3]

As part of its regulatory function, HIQA is responsible for assessing if public and private facilities providing medical and dental radiological services in Ireland are compliant with the regulations. HIQA also has the role for generic justification of practices, which involves collaboration between the Health Technology Assessment Directorate and the Healthcare Regulation Directorate within HIQA. An amendment to the regulations in October 2022 placed the responsibility on HIQA to establish national procedures for clinical audit for radiological practices in Ireland, and this body of work to meet this regulatory function commenced in quarter four of 2022. This is further described under Section 7.8.

In order to carry out its function, HIQA monitors services and carries out inspections. HIQA has adopted a common Authority Monitoring Approach (AMA). This means a risk-based approach is taken to carrying out regulatory activities, which is in accordance with Regulation 25 of the regulations.

7.1 HIQA's ionising radiation regulatory programme

Since the commencement of the regulations, HIQA has been developing its regulatory programme, while gaining a general assessment of compliance in the various sectors and service types which are under its remit. Regulatory activities including monitoring, inspection and enforcement are prioritised and resourced on the basis of the risk posed by services. Available information on each installation, including history of compliance, receipt of notifications and unsolicited information are considered in this assessment of risk. HIQA carries out the following types of inspections:

- **Monitoring inspections**: these are routine inspections that monitor the quality of the service provided by an undertaking[xv] and the level of compliance.

[xv] An undertaking is a service provider that carries out, or engages others to carry out, a medical exposure such as X-rays, radiation therapy etc.

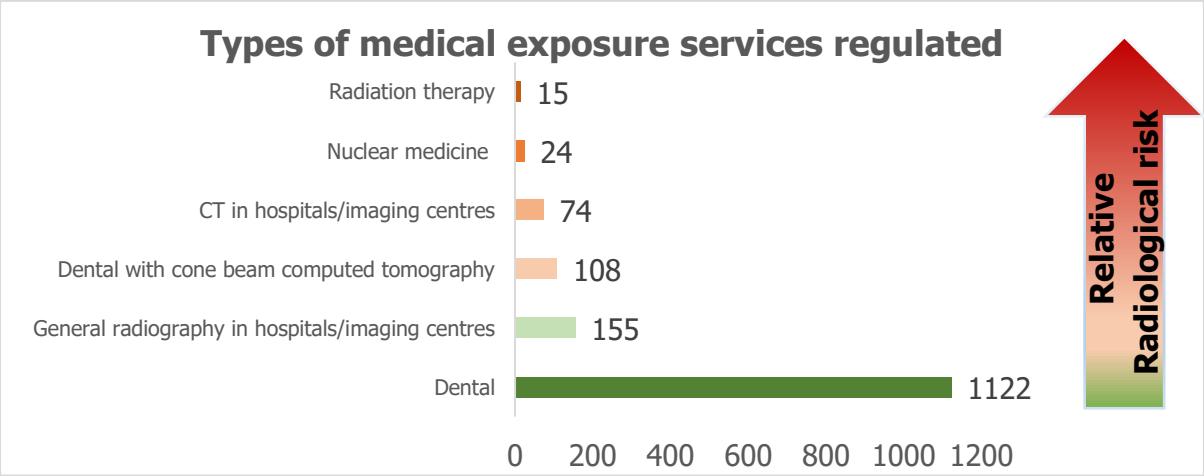
- **Inspections in response to risk:** these are in addition to routine inspections and are carried out when information has been received and assessed which indicates that there may be a risk posed to service users.

Further to the regulatory risks outlined above, the regulatory programme takes into account the accepted varying levels of risk from radiation in different service types, such as a dental clinic and a radiotherapy treatment facility.

7.2 Ionising radiation services under HIQA's remit

Currently, HIQA is responsible for regulating 1,394 medical radiological facilities in Ireland which conduct medical exposure to ionising radiation. These include a range of services from large acute hospitals which deliver multiple types of medical radiological procedures, to small dental practices. The majority of services have a typically lower medical radiological risk, with over 1,200 services providing dental X-rays (including dental with cone beam computed tomography (CBCT)). Figure 12 below outlines the types of services providing medical exposure to ionising radiation and related radiological risk.

Figure 12. Types of radiological services which are currently being regulated by HIQA

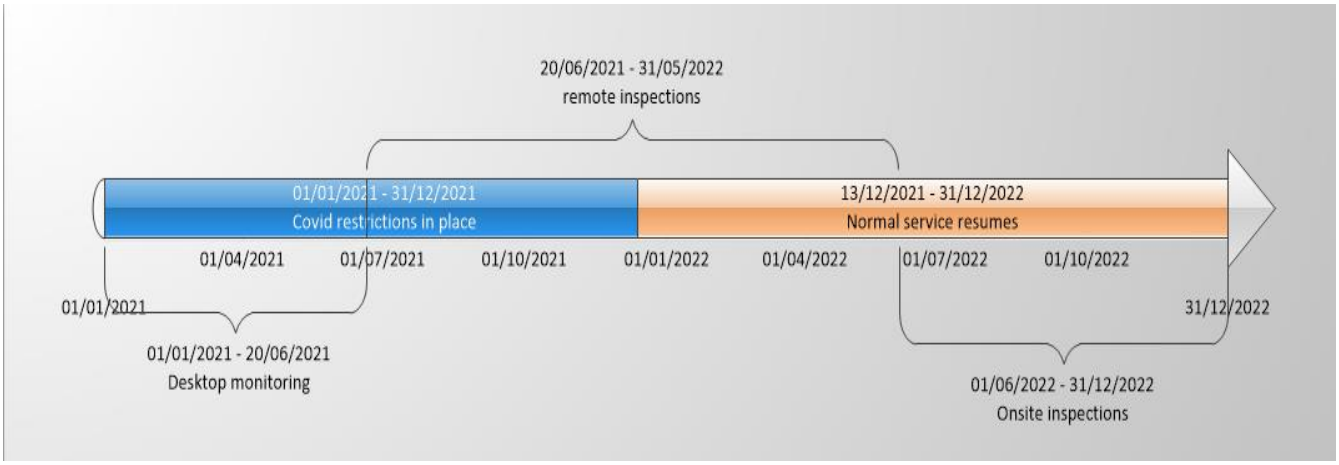


7.3 Regulation of medical exposure in 2021-2023

HIQA continued its regulation programme in ionising radiation in 2021 and 2022 despite challenges posed by the COVID-19 pandemic and the cyberattack experienced by the HSE. HIQA adapted its approach to inspection in response to limitations posed by the COVID-19 pandemic by developing a methodology to facilitate risk-based focused inspections to be carried out remotely. This approach also facilitated HIQA to fulfil its function in line with the regulations.

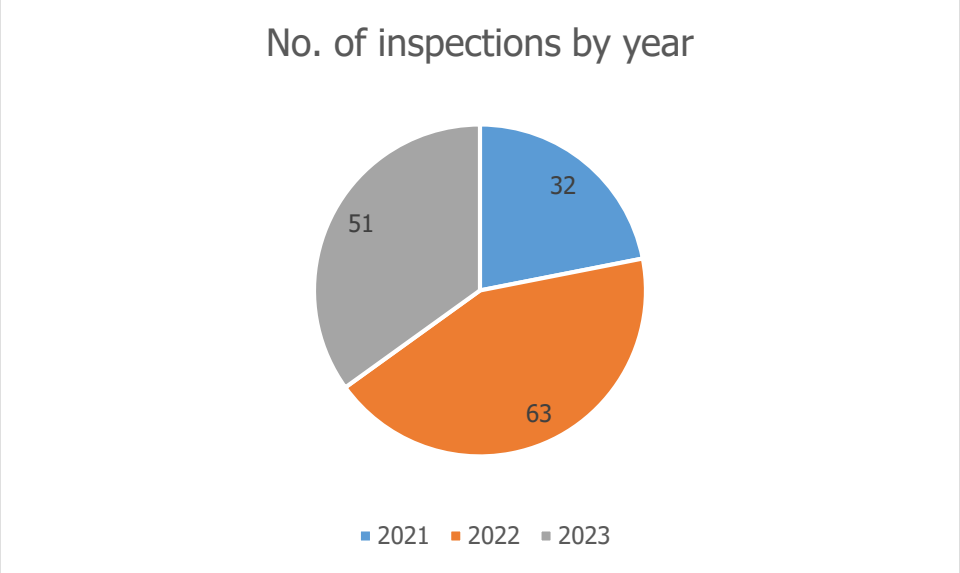
A timeline of HIQA's monitoring programme conducted in 2021 and 2022 is presented below in Figure 13 and shows that a number of methodologies were applied during the pandemic, which included desktop monitoring, remote and on-site inspections. These methodologies enabled HIQA to continue to monitor and assess services during the period when national public safety measures were in place. Inspectors carried out 18 inspections using a remote methodology between 2021 and 2022. While most COVID-19 restrictions were removed in January 2022, remote inspections continued in the dental sector up to May 2022 when on-site inspections recommenced. This also coincided with the return of normal services in most hospitals and imaging centres. There was a notable increase in the number of inspections carried out in 2022 and 2023 when compared with 2021 data.

Figure 13. Timeline of HIQA's monitoring of medical radiological facilities carrying out medical exposures involving ionising radiation in 2021-2023



Overall, a total of 146 inspections were carried out by HIQA inspectors to assess compliance with the regulations between January 2021 and November 2023. A total of 32 were completed in 2021, with 63 conducted in 2022, and 51 completed in 2023 up to end of November 2023 (Figure 14).

Figure 14. Total number of inspections completed in 2021-2023



7.4 Summary of overall compliance with regulations in 2021-2023

Regulations assessed during inspections are grouped and reported under two dimensions; governance and management for medical exposures and; the safe delivery of medical exposures. Not all regulations are assessed during every inspection, as some inspections and or re-inspections may be focused on a particular area of risk or enquiry that is based on information available to the inspector prior to the inspection. In the majority of inspections, inspectors assess core regulations from each dimension, therefore, comparison of overall compliance levels achieved in between 2021-2023 are based on core regulations inspected and are presented in Figure 15.

Figure 15. Summary of overall compliance with core regulations assessed in 2021-2023

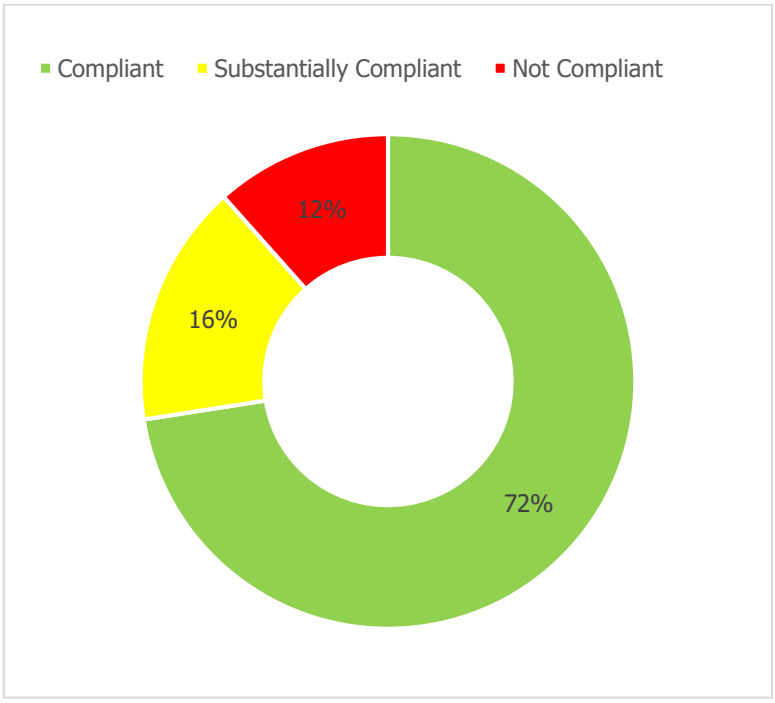
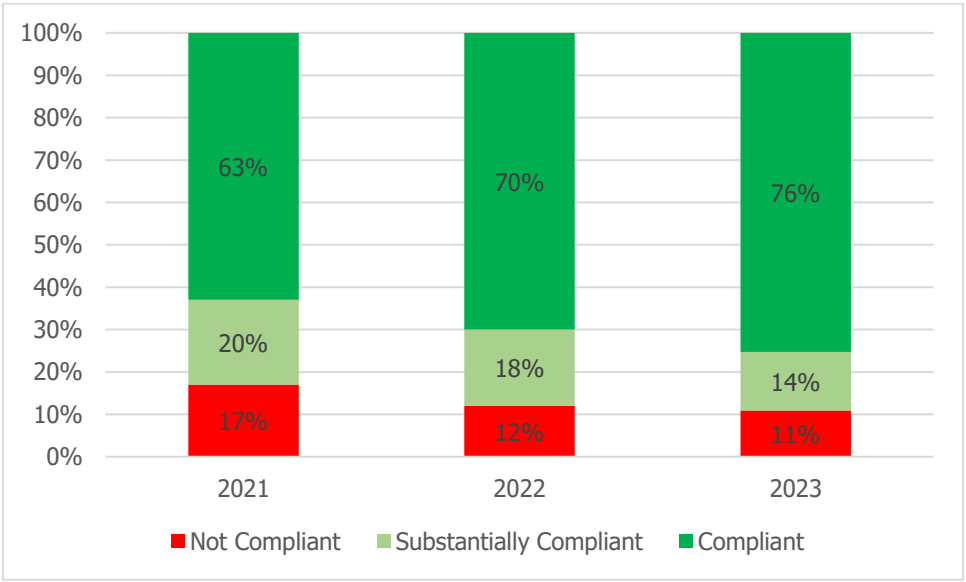


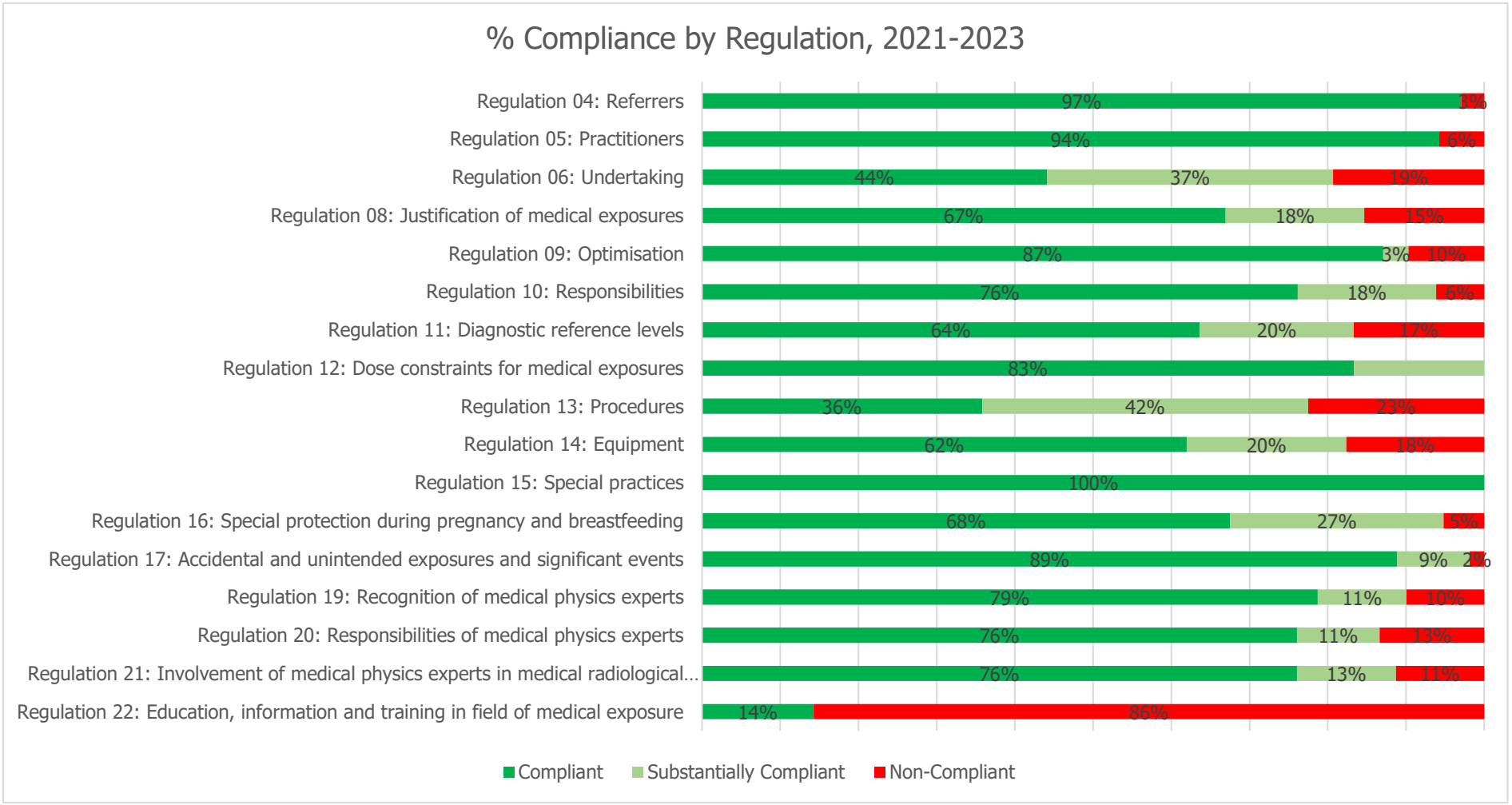
Figure 16. A comparison of the summary of compliance levels with core regulations in all types of services inspected in 2021-2023



There was a significant increase in the number of inspections carried out in 2022. Overall compliance findings with core regulations improved year on year in 2022 and 2023 when compared with 2021 data (Figure 16), which is a positive finding and demonstrated that undertakings are working towards improving compliance with the regulations.

Data presented in Figure 17 shows compliance assessed for each regulation in 2021-2023. It is worth noting that the relatively low level of compliance under Regulation 22 (Education information and training in field of medical exposure) is due to the fact that it is typically only assessed when there is a query in relation to the training levels demonstrated by practitioners and those that conduct medical exposures under the regulations. Since the commencement of the regulations, HIQA has awaited clarity from key professional registering bodies listed under Regulation 22 to further define training requirements for dentists, nurses and medical professionals in order for this to be evaluated as a core regulation. Guidance in relation to training requirements have since been published by the Irish Dental Council and the Nursing and Midwifery Board of Ireland.[9, 10]

Figure 17. Compliance levels with all regulations found in all service types inspected in 2021-2023



Positive findings

From 2021-2023, good levels of compliance were seen in relation to Regulations 4 (Referrers) and Regulation 5 (Practitioners) as outlined in Figure 17 above. The compliance found is consistent with findings from inspections conducted in 2020.

Referrers and practitioners are persons named in the legislation. A referrer is a person who is entitled to refer an individual to a practitioner for a medical exposure, and a practitioner is a person entitled to take clinical responsibility for that medical exposure. The inspections found that in most cases, the persons referring service users for medical radiological exposures and those who took clinical responsibility for those procedures were appropriate registered professionals in line with the regulations.

Good levels of compliance were also evident for Regulation 17 relating to accidental and unintended exposures and significant events. This demonstrated that undertakings had the systems in place to manage, record and analyse trending of events and potential events and that these systems minimised the probability and magnitude of accidental or unintended exposures taking place.

Examples of good practice found during inspections carried out in all facilities in 2021-2023

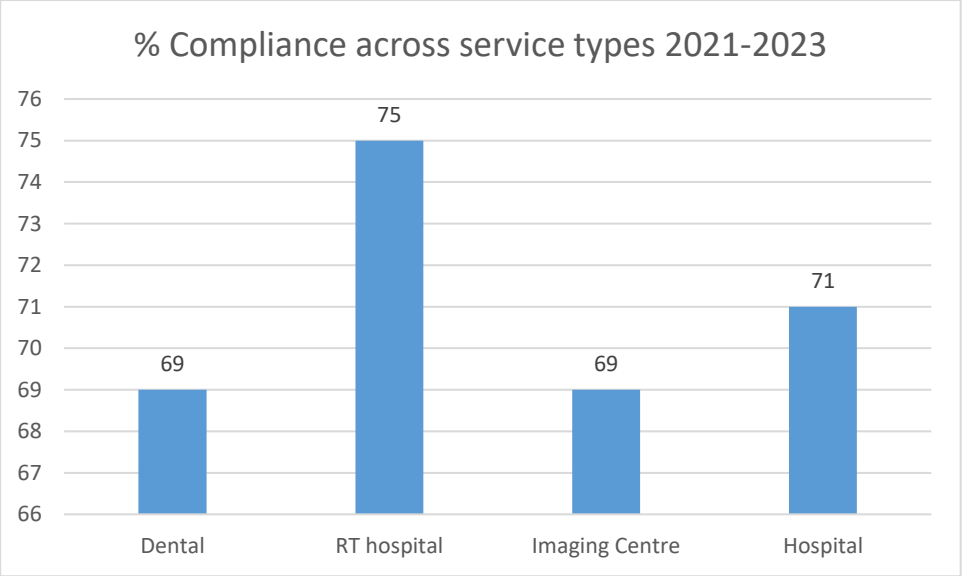
Inspectors found examples of good practice during the inspections carried out from 2021-2023, a sample of which are listed below;

- There was evidence of consistent attendance at local governance meetings and subsequent actions taken, with evidence of clear lines of communication from clinical to corporate governance in a large hospital, up to the undertaking overseeing multiple hospitals.
- In a dental practice, the allocation of responsibilities for justification, optimisation and Medical Physics Expert (MPE)[xvi] responsibilities as per the regulations were clearly documented and these were also communicated consistently by staff involved in the service.
- Evidence that formalised arrangements were in place with an MPE to support the service and to give advice on matters relating to medical physics.

[xvi] A Medical Physics Expert is a person defined in the regulations, who has the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to medical exposure.

- Quality assurance (QA) and performance testing was carried out in a timely manner and any actions arising from the MPE QA had been actioned by the undertaking.
- Radiation therapy (RT) facilities tend to demonstrate better compliance on inspection (Figure 18).

Figure 18. Compliance levels in different service types inspected from 2021-2023



Areas for improvement

From the inspections carried out in 2021-2023, improvements in compliance is required with respect of several regulations. For example, Regulation 6 specifies the need for a clear allocation of responsibilities for the radiation protection of persons undergoing medical exposure to ionising radiation. Inspectors found that only 44% of facilities assessed met the requirements of this regulation.

Regulation 13 relates to procedures, and inspectors found that 23% of services were not compliant this regulation. Most of these non-compliances related to the patient exposure not forming part of the report of the procedure. There were similar findings for Regulation 14 in relation to equipment, with 18% of services non-compliant in 2021-2023. The non-compliances were a result of instances where the undertaking failed to keep equipment under strict surveillance and failed to implement and maintain a QA programme.

In instances where a high risk has been identified, HIQA identifies the date by which the undertaking must comply. An example of such high risk finding was where a practitioner, as per the regulations, was not found to be involved in the justification

of medical exposures at a particular facility. In this case, due to the particular risk identified, HIQA issued an urgent compliance plan to the undertaking and specified a date to come into compliance within a short timeframe. In other circumstances, where a non-compliance is identified which does not pose a significant risk to the safety, health and welfare of service users, the undertaking must take action within a reasonable time frame, determined by the undertaking, to come into compliance.

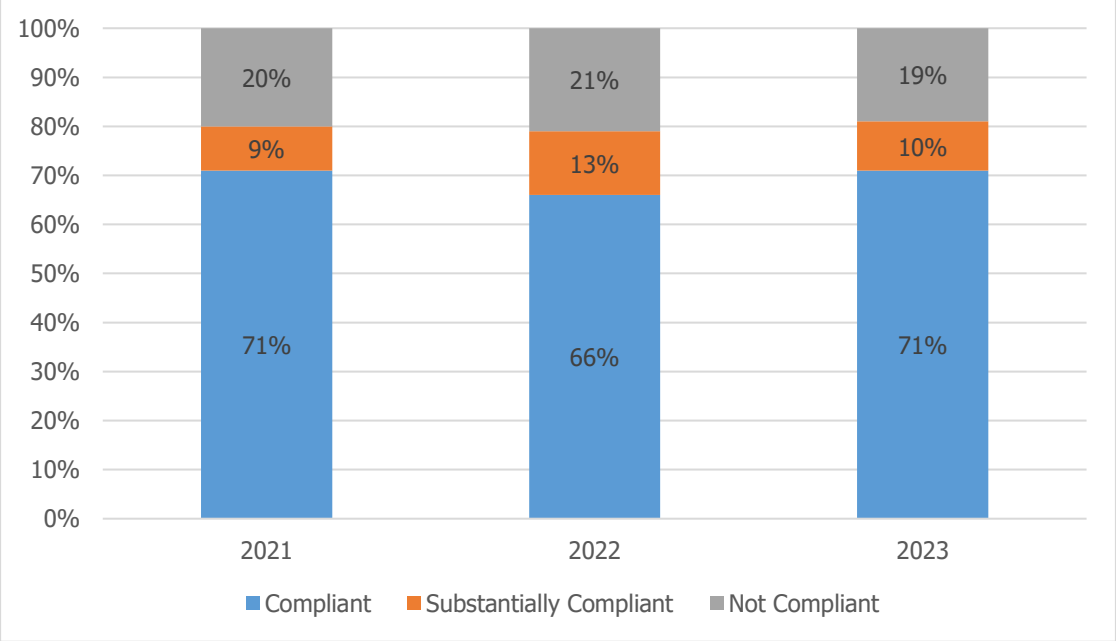
7.5 Regulation and monitoring of the dental sector

HIQA is currently regulating over 1,200 dental services which carry out medical exposure to ionising radiation. Throughout 2021-2023, HIQA has continued to monitor dental services through the receipt and assessment of self-assessment questionnaires (SAQs) and by inspection where required. The self-assessment questionnaire is a tool that allows undertakings to self-appraise their baseline level of compliance on how X-rays are conducted. It helps services to identify any possible risks or perceived gaps in practice. The tool also helps HIQA to understand the levels of compliance with the regulations at various services from a desktop perspective. However, it is important to note that the submitted information provided to HIQA is not validated information and relies on self-declaration on behalf of the undertaking.

Due to the number of dental services under HIQA's remit, SAQs were issued on a regional basis to undertakings. SAQs continue to be issued to new undertakings and or new dental services following notification to HIQA of the intention to commence practices involving medical exposure to ionising radiation. In 2021, 299 questionnaires were returned to HIQA and were reviewed by inspectors. In 2022, the number of questionnaires returned increased to 794 with a further 127 issued in 2023. The SAQs that were assessed by inspectors to require improvements, were subsequently followed up either by engaging with the undertaking, requesting further information through an undertaking assurance report or by conducting an on-site inspection to assess compliance. In addition, HIQA also inspected a sample of facilities that had self-assessed its service as compliant with all regulations in the SAQ submitted. While self-assessed compliance was generally consistent with what inspectors found on inspection, some were not.

As part of the notification process to HIQA in 2019, HIQA requested undertakings to nominate a designated manager of each service with responsibility for the day-to-day management of the medical radiological installation. Inspectors noted that the issue of communication regarding SAQs prompted many undertakings to update contact information or information about the service, such as the named designated manager. It is important that the service providers keep HIQA up to date to ensure that we have the correct information about the service in our directory. Figure 19 represents the overall compliance of dental facilities inspected in 2021-2023.

Figure 19. A comparison of the summary of compliance levels with core regulations found in dental services inspected in 2021-2023

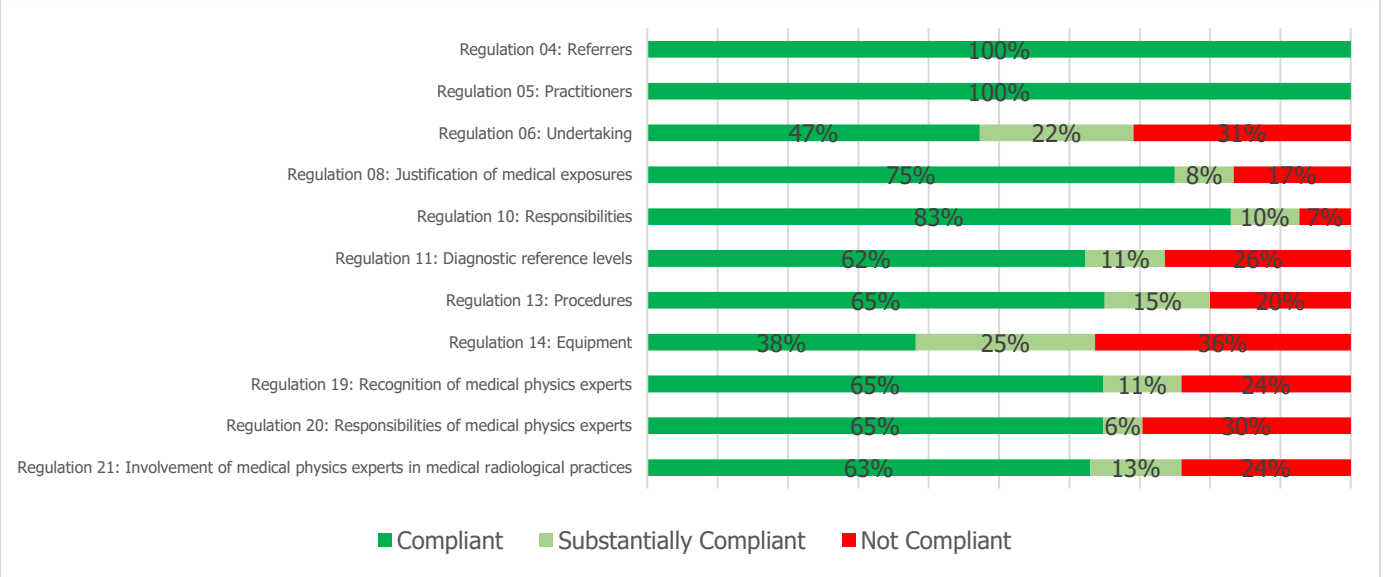


Positive findings

High levels of compliance were found in the dental sector, particularly in relation to Regulations 4 (Referrers) and 5 (Practitioners) as seen in Figure 19 below. Compliance with these regulations were found from both SAQs and inspection, with almost full compliance in both regulatory exercises. This provides assurance that in the dental sector, appropriate professionals in accordance with the regulations are referring patients for dental procedures and are taking clinical responsibility for those procedures.

Similarly, where reviewed on inspection, good levels of compliance were found for Regulation 17 relating to accidental and unintended exposures and significant events. In the dental sector, this regulation is assessed through review of documentation in place and how staff and management communicate the process for recording and reporting any events involving, or potentially involving, accidental or unintentional dental exposures at the practice.

Figure 20. Compliance levels with core regulations found in dental services inspected in 2021-2023



Key findings from the dental sector:

- High levels of compliance were found on inspection for regulations concerned with referrers (Regulation 4), practitioners (Regulation 5) and responsibilities (Regulation 10).
- A clear allocation of responsibility for medical exposures under Regulation 6 was not always evident, as full compliance was only demonstrated in 47% of dental services inspected. Services must have an effective management system in place relative to the scale of the service, for example, in situations where an undertaking had failed to engage a MPE to be appropriately involved in their service. In this scenario, the failure to ensure that there is a clear allocation of responsibility, ensuring that an MPE is appropriately engaged for the service, can also impact compliance with other regulations.
- 20% of dental inspections in 2021-2023 were found to be non-compliant with Regulation 13: Procedures. In many situations, this related to an absence of written protocols for every type of standard dental radiological procedure on the day of inspection.
- 2.5% of services told HIQA they had not adequately involved an MPE in their dental service in a self-assessment questionnaire. This compares with 24% found with a non-compliance finding on inspection.
- 61% of the inspections identified room for improvement with regard to Regulation 14 relating to equipment. In some cases, quality assurance by the MPE was overdue and there were also findings where equipment was installed and used clinically prior to having acceptance testing completed by the MPE.

7.6 National diagnostic reference levels (DRLs)

As the Competent Authority for medical exposure to ionising radiation on behalf of the State, HIQA is required to fulfil a number of roles which complement the regulation of services through inspection and monitoring to improve the quality and safety of services. One of these functions is the review of national diagnostic reference levels (DRLs). National DRLs are representative of typical doses service users receive as part of their diagnosis. They provide a standard for comparison to help ensure the radiation protection of patients undergoing these types of medical radiological procedures.

Following a national survey conducted of service providers in Ireland, HIQA published updated national diagnostic reference levels (DRLs) for general radiography and mammography in 2021.[11] As part of this report, HIQA has also published national dual-energy X-ray absorptiometry (DXA) DRLs and this was the first time that DRLs for these procedures were produced in Ireland.

HIQA's survey found that the levels of radiation that patients are being exposure for these types of procedures have reduced by between 2-27% since the previous survey. Furthermore, for the vast majority of procedures reviewed, the radiation doses are below that referenced in guidance issued by the European Commission. The new national data allows service providers to compare the levels of radiation used at their service with these national levels to identify medical radiological procedures which may require review and put corrective actions in place where needed.

In 2021, HIQA commenced a review of fluoroscopy and fluoroscopically guided intervention imaging doses. This required extensive stakeholder engagement to develop a clinically-appropriate national catalogue of common fluoroscopy and fluoroscopically guided intervention imaging procedures. The diagnostic reference level survey tool was received by 64 undertakings and review of responses commenced in 2021. The results of this survey were published in 2022 following the review and assessment of individual responses.[12]

In 2022, a review of nuclear medicine DRLs commenced, surveying 24 facilities where diagnostic nuclear medicine procedures are carried out. The results of this nuclear medicine DRL survey were published in November 2023 and included DRLs for the CT hybrid component of nuclear medicine imaging for the first time in Ireland.[13]

The review of national DRLs by HIQA will be carried out and published on a continuous basis. By doing so, HIQA aims to share learnings to help service providers optimise patient doses to further improve safety around ionising radiation

in Ireland. While HIQA has responsibility for publishing national data, undertakings have responsibility for establishing and reviewing local facility DRLs, and comparing these to national data. Facility level DRLs should be reviewed regularly and this process should be incorporated into the undertaking's quality assurance programme.

7.7 Overview of lessons learned from receipt of statutory notifications of accidental and unintended exposures 2021-2023

Overview report of lessons learned from receipt of statutory notifications of accidental and unintended exposures 2021

In September 2022, HIQA published its third annual overview report of lessons learned from the receipt of statutory notifications of accidental and unintended exposures to ionising radiation and compared findings across all years.[14]

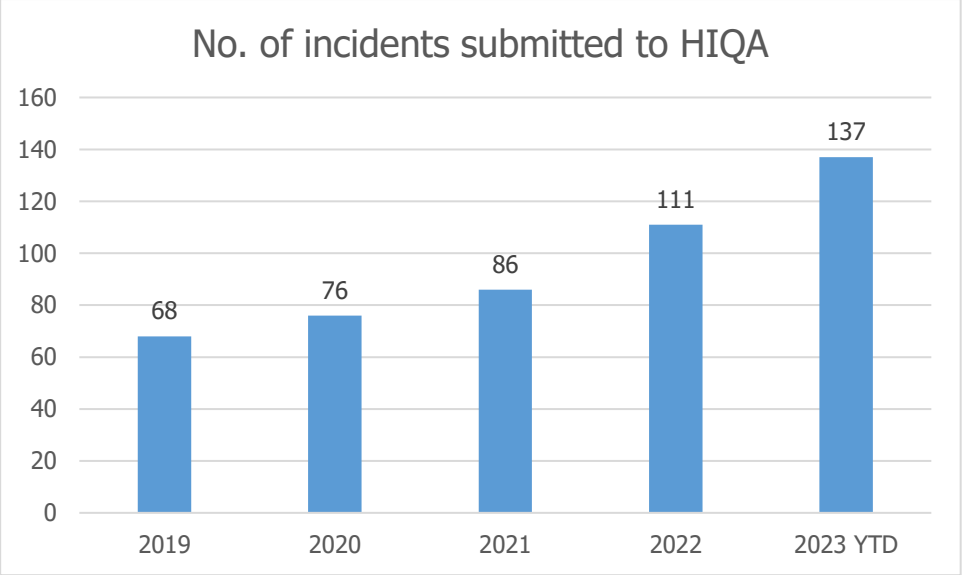
The majority of notifications received were from diagnostic imaging services with most of the reported incidents occurring in computed tomography (CT) services. Radiotherapy incidents accounted for 14% of the total number of notifications received, all of which related to external beam radiotherapy.

Overview of lessons learned from receipt of statutory notifications of accidental and unintended exposures in 2022 and 2023

This section of the report relates to notifications received in 2022, and by end of November 2023. It also provides an opportunity to outline a year-on-year analysis of the numbers and types of incidents reported to HIQA. The aim of this section is to share the learning with service users and undertakings on the circumstances that may contribute to a radiation incident, and how such events may be prevented from happening again. The primary focus is to protect persons using the services from the unwanted and unintended effects resulting from accidental or unintended exposures to ionising radiation. Two examples of case studies on ionising radiation incidents to support learning are included in Appendix 5.

In total, in 2022 HIQA received 111 notifications which met the defined thresholds of reportable significant events, and this has increased to 137 by the end of November 2023. This number has risen every year since 2019. HIQA sees this as a positive indicator, and encourages undertakings to continue their efforts to improve the level of reporting in the interest of promoting wider system learning for the benefit of patient safety.

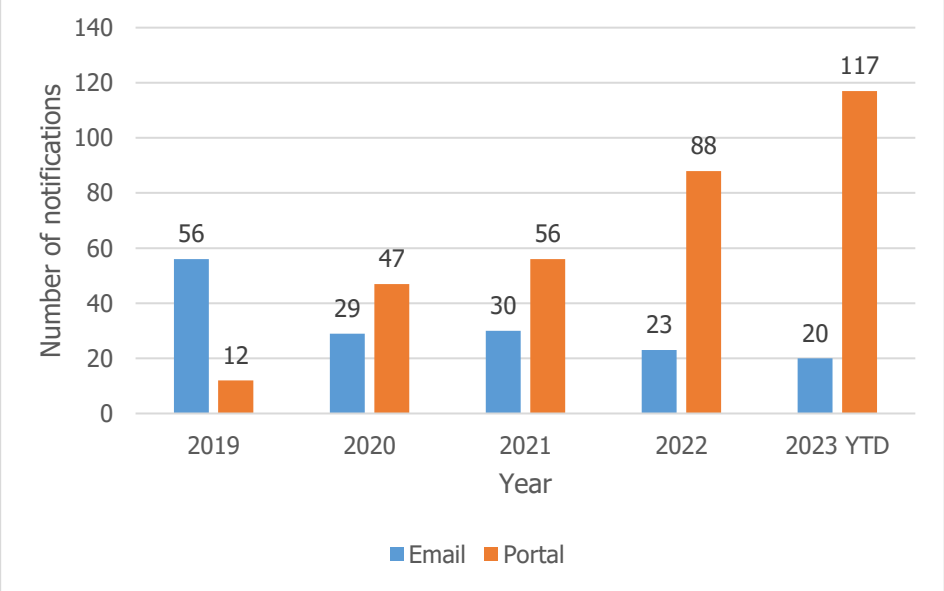
Figure 21. Number of incidents reported to HIQA (2019-2023)



Undertakings can report incidents to HIQA by email or by using HIQA's online portal system. HIQA's portal system offers a streamlined, secure and easy-to-use method for undertakings to submit notifications. It also provides the undertaking with an accessible record of the incident's history and facilitates oversight of trending of notifications submitted to HIQA.

Of the 111 notifications submitted during 2022, 88 (79%) were submitted using the portal system, with the remaining 23 (21%) notifications submitted by email. In 2023, 117 (85%) were submitted by portal. The trending of this data since 2019 can be seen in Figure 22.

Figure 22. Methods used to submit notifications to HIQA (2019-2023)



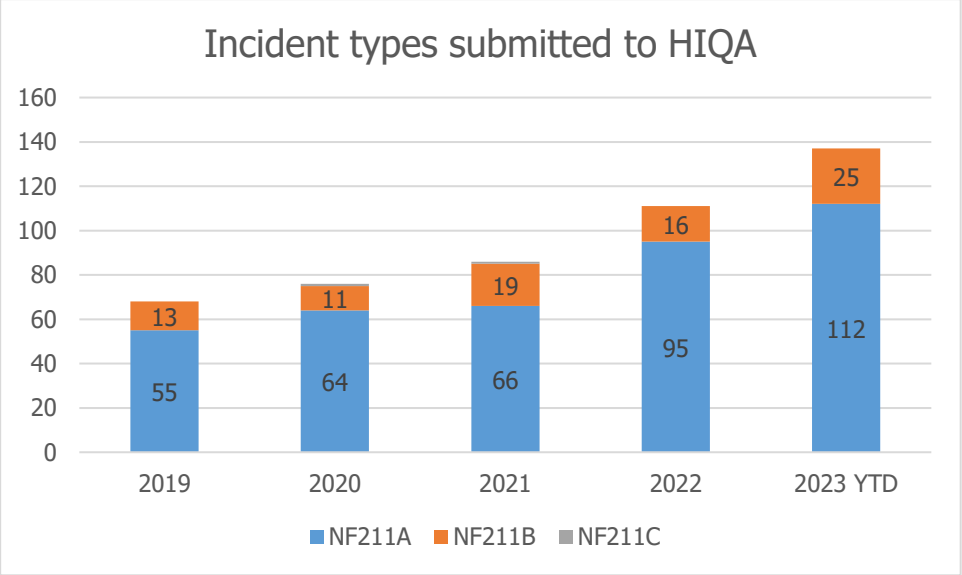
Types of radiation notification submitted to HIQA

Undertakings are asked to assign each accidental and unintended exposure or significant event to one of the following categories at the initial notification stage:

- NF211A – Diagnostic Imaging (Dental/Radiology/Nuclear Medicine)
- NF211B – Radiotherapy
- NF211C – Other.

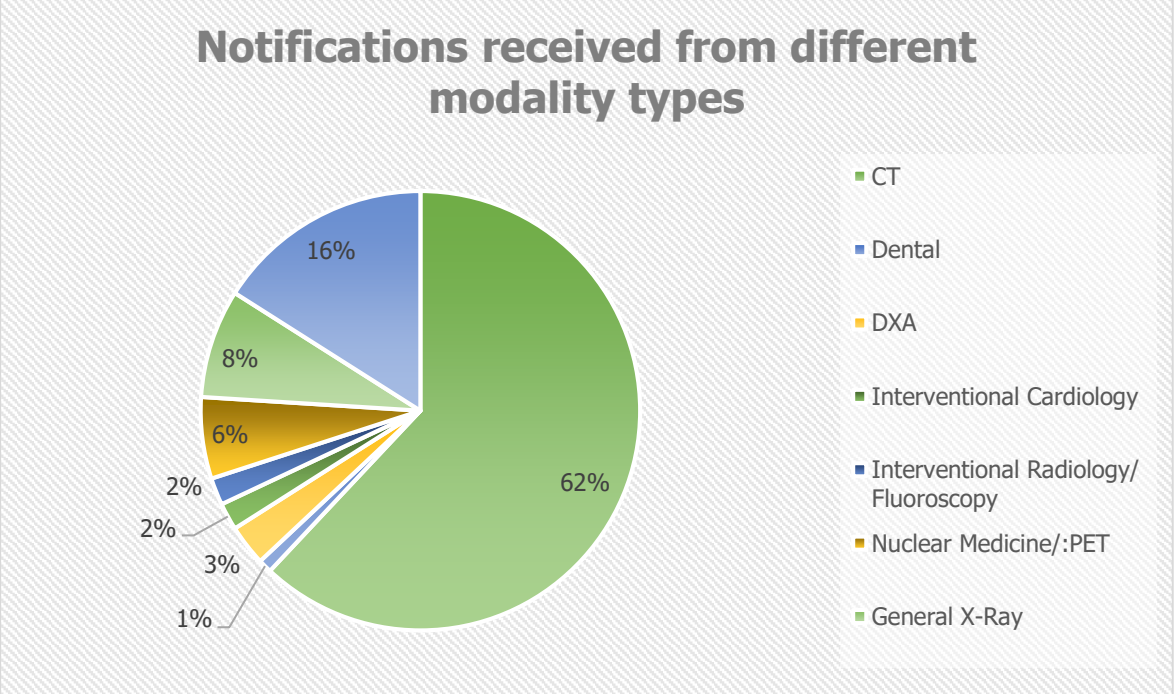
Diagnostic imaging and radiotherapy services are considered separately due to differences in operational service delivery, equipment and staff. The third category of 'Other' provides a reporting pathway for incidents that undertakings determine may not be easily categorised. The contribution of each notification type to the overall number of incidents reported to HIQA since 2019 is included in Figure 23.

Figure 23. Notification type (2019-2023)



Trends in the contribution of each notification type can be seen with those from diagnostic imaging outweighing those reported by radiotherapy consistently since 2019. This is largely due to the number of diagnostic imaging facilities far outnumbering the number of radiotherapy facilities. The higher overall number of diagnostic procedures completed annually may be another contributing factor. In Figure 24, 62% of notifications are in relation to computed tomography, 16% are from radiotherapy, 8% from general radiography, 6% from nuclear medicine and PET, with the remaining 8% split between DXA (3%), interventional radiology fluoroscopy (2%), interventional cardiology (2%) and dental (1%).

Figure 24. Notifications received from modality types in 2022 and 2023

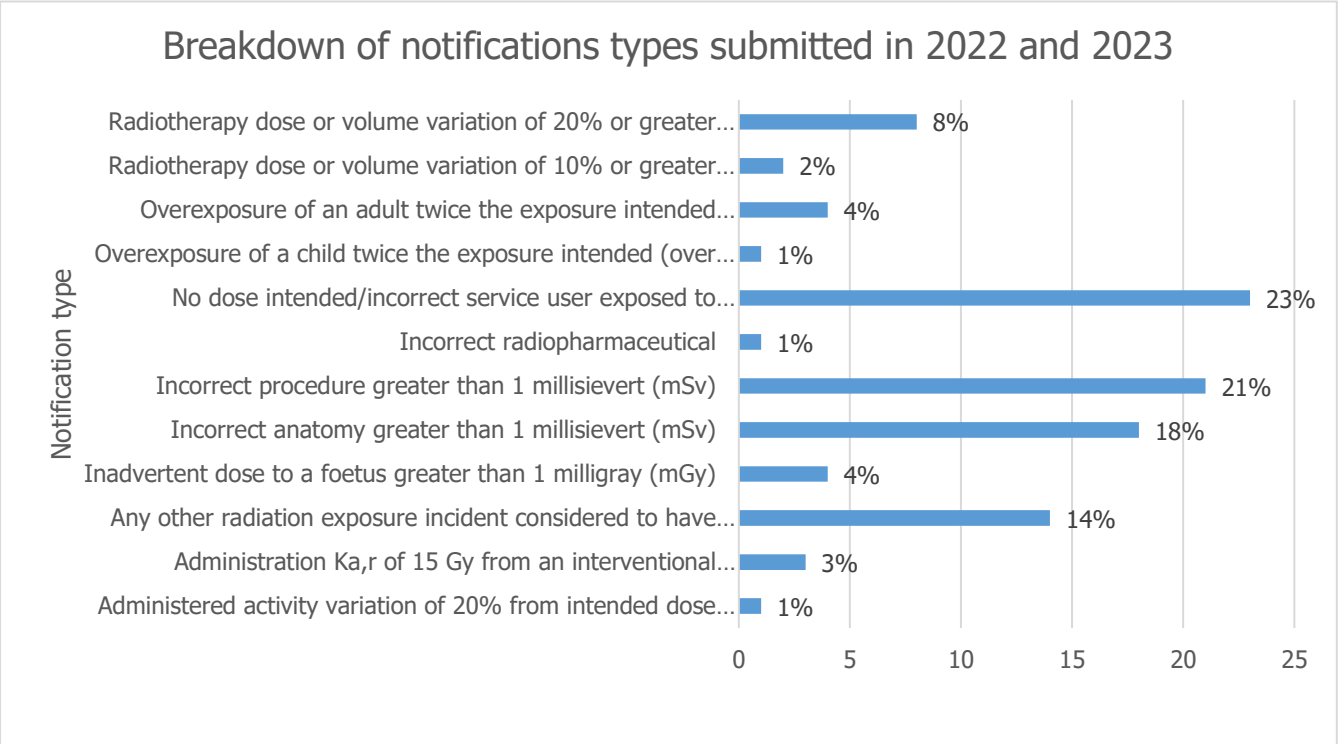


Undertakings are asked to categorise the nature of the incident as part of the reporting of accidental and unintended exposures or significant events.

As seen in Figure 25, trends in the nature of incidents are evident since 2019, the most common incidents reported to HIQA in 2022 and 2023 were:

- No dose intended or incorrect service user exposed to greater than 1 millisievert (mSv) - 23%
- Incorrect procedure greater than 1 millisievert (mSv) - 21%
- Incorrect anatomy greater than 1 millisievert (mSv) - 18%
- Any other radiation exposure incident considered to have serious service user safety implications - 14%.

Figure 25. Notification category in numbers (2022 and 2023)



Factors that lead to incidents and corrective actions taken

When undertakings were asked to assess the main cause of accidental and unintended exposures or significant events reported, human error remains the most common reason cited for incidents occurring.

It was also found that corrective actions implemented in response to significant events in 2022 and 2023 were often low-to-medium level strategies. There was evidence that multiple corrective actions were implemented in some cases, such as education and information, reminders, checklists and double checks and updating of rules and policies. These measures are people focused, and in general, were proportionate with the identified risk associated with the incidents. The effectiveness hierarchy of corrective measures is outlined in Table 5.

Table 5. Corrective measures used by undertakings ranked by effectiveness

Risk reduction strategies/corrective measures	Effectiveness
Forcing functions	High
Automation and computerisation	High
Simplification or standardisation	Medium

Reminders, checklists and double checks	Medium
Rules and policies	Low
Education and information	Low

Summary of lessons learned from receipt of statutory notifications of accidental and unintended exposures in 2022 and 2023

In settings where medical exposures are carried out, it is imperative that the incident culture and systems encourage staff to identify and report all actual and potential incidents, including 'good catches' and near misses. Furthermore, by analysing and trending all such incidents, the undertaking improves the quality of the data obtained through these systems, and can identify 'weak spots', or areas for improvement in the service. Implementing changes, based on incident trending data, improves service user safety and positively impacts everyone involved in the service.

Since 2019, there has been a year-on-year increase in the number of notifications received by HIQA. HIQA has also observed a steady increase in the number of undertakings and facilities submitting notifications during in 2022 and 2023.

HIQA noted that the corrective actions implemented in response to significant events were often low-to-medium level strategies. Higher-level strategies such as automation and computerisation and forcing functions are considered more effective, as they are systems focused, and should be considered by facilities in incident management.

In 2024 and beyond, HIQA's programme of monitoring and inspecting services will continue in order to ensure that radiation protection practices in public and private radiological facilities in Ireland are compliant with the regulations. HIQA will continue to build upon this programme to promote patient safety in relation to radiation protection, and to improve the quality and safety of medical exposures for service users.

7.8 Future direction of the medical exposure to ionising radiation regulatory programme

HIQA continues to provide guidance to support undertakings. In November 2023, HIQA published *National procedures for clinical audit of radiological procedures involving medical exposure to ionising radiation.*[15] The national procedures set out the principles and essential criteria that services must follow to ensure compliance with the requirements of the regulations. Information on implementing clinical audit,

and examples for each type of setting is provided, with some templates and resources that undertakings may find useful, with hyperlinked sections to facilitate easy navigation. The integration of this guidance into every day practice will be included in inspections in the coming months.

HIQA's inspection programme is now well established in line with regulatory requirements and function. HIQA is committed to further developing our graded approach to regulation. This approach will consider the scale and nature of the potential hazard associated with practices, and will help to inform how frequently HIQA inspects an undertaking. It will also inform the nature, intensity and type of any inspection carried out. HIQA will continue to progress a graded approach to inspection, taking in account these recommendations.

As previously mentioned, HIQA's role as the competent authority has continued to expand. This means that inspectors will assess the undertaking's compliance with the implementation of the national procedures for clinical audit in each facility following its publication. Similarly, inspections will also include the assessment of compliance with justification of new practices.

8. What people told us about services and how we engaged with stakeholders during 2021-2023

As a regulator, HIQA receives information from a variety of sources. This information may be categorised into solicited (requested) and unsolicited information. Unsolicited information (UROI) is defined as information which is not requested by HIQA, but is received from people, including the public or people who use services. This could be information that indicates a non-compliance with the regulations or standards (information of concern), a compliment, or a general comment about a designated centre, a hospital or a children's social care service.

8.1 Feedback about healthcare services

HIQA welcomes feedback about people's experiences of services to inform the assessment of the quality of care received within healthcare services. This information can be received from service users, their family members or advocates, health and social care professionals, employees, and the general public.

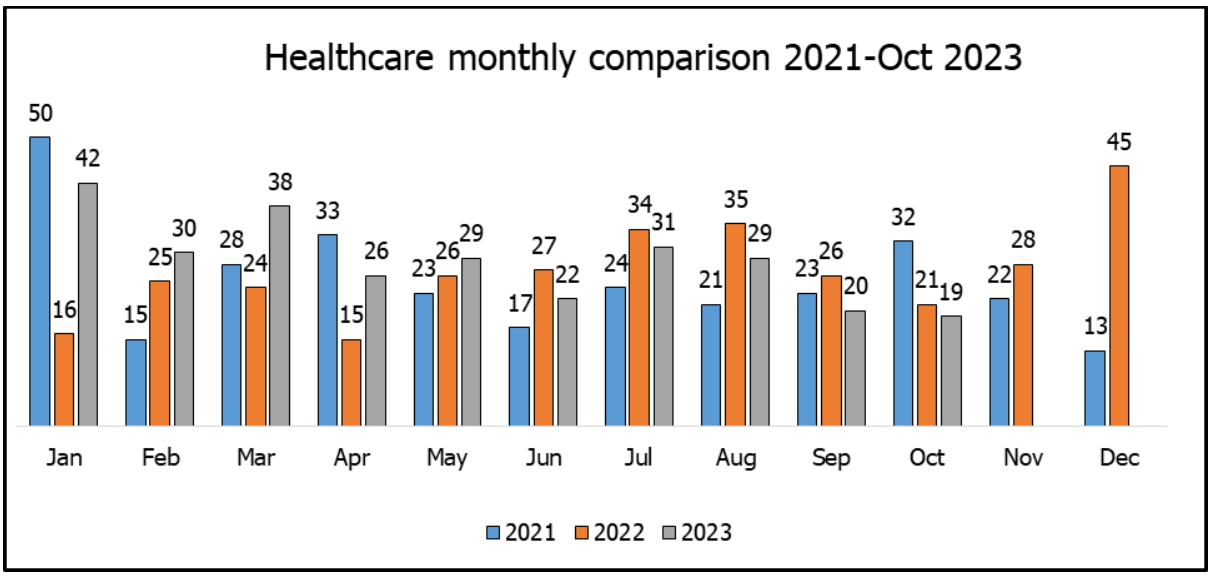
While HIQA has no legal remit to investigate an individual complaint about care under the Health Act 2007, it uses this information to monitor the quality and safety of care. All information received is reviewed and risk rated, and used alongside the other information gathered about a service to inform regulatory judgments.

This section of the report sets out a detailed analysis of all unsolicited information received in 2021 and 2022, and up to the end of October 2023. It also sets out how HIQA used this information to inform our work.

In 2021, HIQA received 1,638 pieces of feedback about health and social care services under its remit. This increased slightly in 2022 to 1,675 pieces of feedback. To the end of October 2023, 1,577 pieces of information have been received.

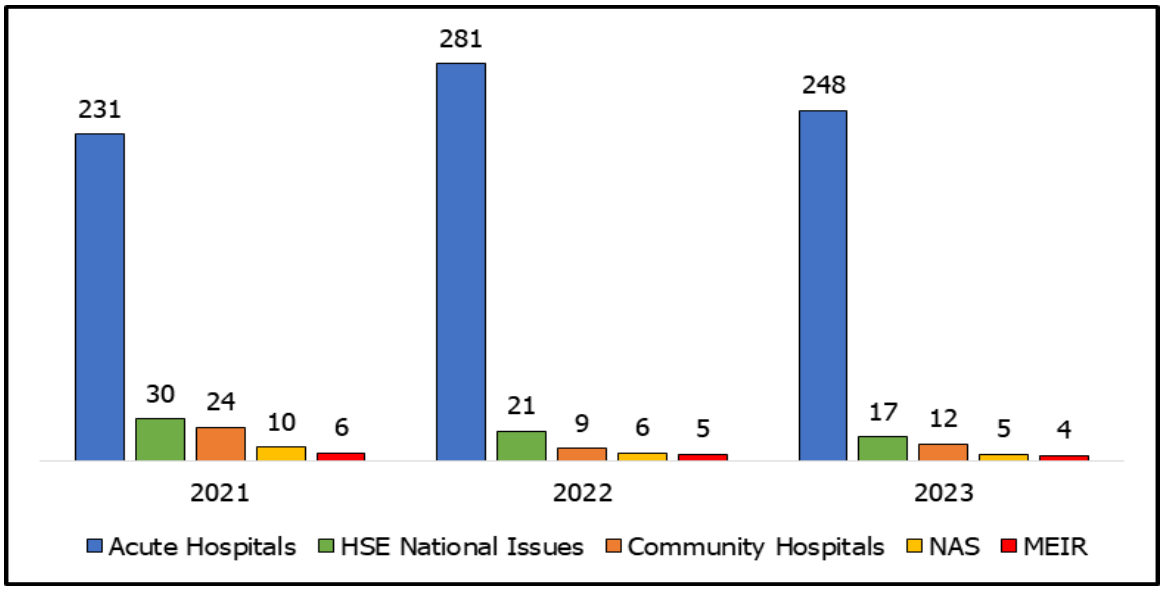
Feedback about acute and community hospitals, medical exposure to ionising radiation services, the national ambulance service, and HSE national services accounted for 18% (301) of the feedback in 2021, 19% (322) in 2022, and 18% (286) of the feedback received to the end of October 2023.

Figure 26. Comparison of number of healthcare UROI received per month 2021, 2022 to end of October 2023



Most of the feedback received about healthcare services came from contact persons external to HIQA. The most frequent services included acute hospital services, HSE national issues, community and rehabilitation hospitals, the National Ambulance Service (NAS) and medical exposure to ionising radiation (MEIR) services. Figure 27 below sets out a comparison of the number of pieces of feedback received about these different types of services in 2021, 2022 and to 31 October 2023.

Figure 27. Comparison of number of healthcare UROIs per service type for 2021, 2022 to end of October 2023

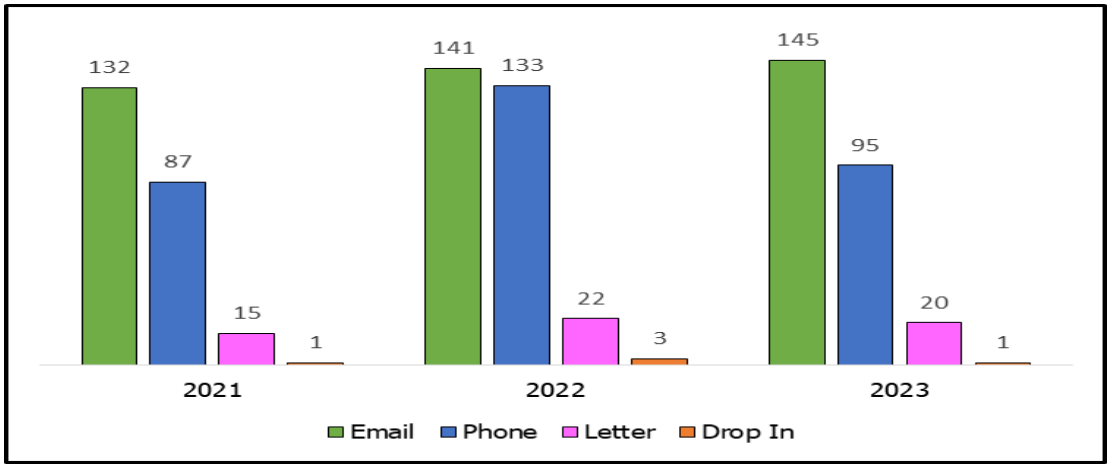


In the current absence of a legal remit to receive statutory notifications[xvii], HIQA also collates and classifies information raised through internal surveillance of data, key national reports and other sources including published literature, coroner's reports and media articles. Of the 301 UROIs raised about healthcare services in 2021, 66 (22%) of these were created by HIQA inspectors in response to internal surveillance.

Of the 608 UROIs managed in 2022 and up to October 2023, 46 were created in response to internal surveillance. Five-hundred and twenty-nine of the UROIs related to acute hospitals, a further 38 related to HSE national issues, 21 related to community hospitals, 11 related to the national ambulance service and nine related to an ionising radiation service.

Of the 909 pieces of information managed from 2021-2023 year to date, 418 were received by email, 315 by phone and 57 by letter. There were also five people who called into a HIQA office to provide feedback about a service.

Figure 28. Comparison of contact method for healthcare UROIs for 2021, 2022 to end of October 2023



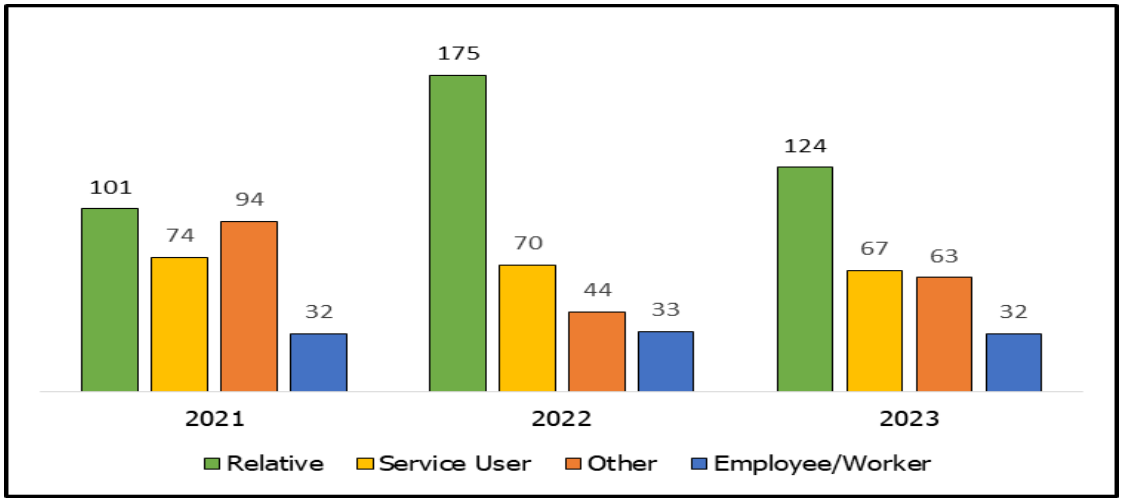
8.2 People who contacted HIQA about healthcare services

People using services accounted for 24.5% (74) of the 2021, 22% (70) of the 2022, and 24% (67) of the 2023 (to 31 October) pieces of feedback received about healthcare services (Figure 29). This figure is higher than the feedback received from service users about any other services within HIQA's remit. Relatives accounted for 33.5% (101) of the 2021, 54% (175) of the 2022 feedback and 43% (124) of 2023. A further 11% (32) of the 2021, 10% (33) of the 2022 and 11% (32) of the 2023 feedback was from employees. HIQA also managed 94 (31%) pieces of

[xvii] The absence of a statutory notification process within healthcare services will change with the commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

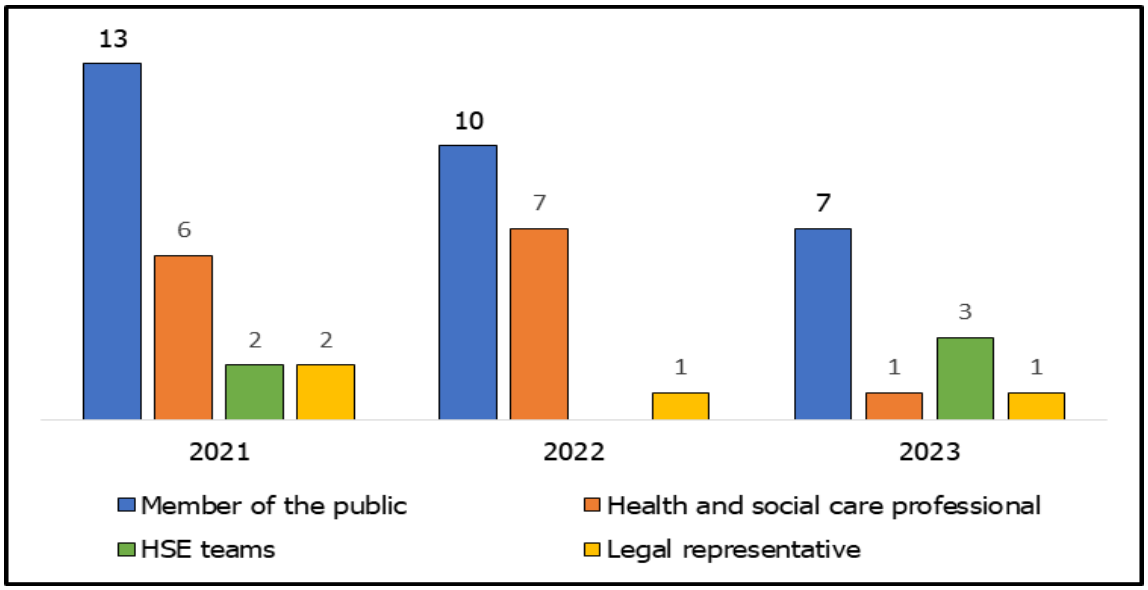
information in 2021, 44 (14%) in 2022 and 63 (22%) from 'others' including members of the public, health and social care professionals and anonymous parties.

Figure 29. Comparison of category of contact person for healthcare UROIs for 2021 to end of October 2023



Excluding the UROIs created on foot of internal surveillance (109), Figure 30 below sets out a comparative breakdown of the most frequent externally sourced 'others' who contacted us throughout 2021, 2022 to the end of October 2023.

Figure 30. Comparison of breakdown of external 'other' category of contact person for healthcare UROIs in 2021, 2022 to end of October 2023



8.3 Qualitative assessment of information received by HIQA

Of the 909 pieces of feedback that were received during 2021, 2022, and to end of October 2023, 894 (98%) related to healthcare services, whilst 16 (2%) related to

an ionising radiation undertaking. In total, nine compliments about healthcare services were received, two in 2021, three in 2022 and four to the end of October 2023.

Nine hundred and nine (909) pieces of feedback were received from 2021 to the end of October 2023, of which 798 UROI were raised by external sources.

Across all feedback received about healthcare from 2021 to the end of October 2023, the five most common themes under the quality and safety dimension were

- safeguarding[xviii] (610)
- rights (570)
- the quality of care (538)
- infection prevention and control measures (174)
- risk management (88).

The breakdown of the quality of care theme included healthcare, assessment and care planning, personal care and medicines management.

The five most common themes under the capacity and capability dimension included

- governance and management (688)
- communication (398)
- staffing (106)
- complaints handling (94)
- information governance (61).

8.4 How HIQA manages unsolicited information

All unsolicited information received is acknowledged, logged and examined by HIQA. The information is reviewed by an inspector to establish if the information received indicates a risk to the safety, effectiveness, and management of the service, and the day-to-day care service users receive. Unsolicited information allows HIQA to:

- ensure services continue to meet high standards of care for service users
- consider how well services handle complaints and use them as opportunities to improve care for service users

[xviii] Safeguarding is the measures that are put in place to reduce the risk of harm, promote and protect people's human rights and their health and wellbeing, and empowering people to protect themselves (National Standards for Adult Safeguarding, HIQA/MHC 2019).

- identify any trends or patterns that could indicate that something unacceptable is happening in a service.

If HIQA considers that the service provider may not be compliant with the national standards, we can respond by:

- asking the service provider to submit additional information on the issue
- requesting a plan from the service provider outlining how the issue will be investigated and addressed
- using the information on inspection
- carrying out an unannounced inspection to assess the quality and safety of the care being provided in the service.

In addition, where the information indicates that people may be at immediate risk, HIQA will use its full legal powers and report the incident, where appropriate, to An Garda Síochána, the Child and Family Agency (Tusla) or the Health Service Executive (HSE's) Adult Safeguarding and Protection Team.

8.5 External Stakeholder engagement in the Healthcare Directorate

In October 2021, HIQA and the EPA signed a Data Sharing Agreement to provide a mechanism to assist cooperation between the two parties to in the best interests of the public.

HIQA continues to represent Ireland as competent authority for medical exposure to ionising radiation at the Heads of the European Radiological Protection Competent Authorities (HERCA) Working Group on medical applications in Europe.

As part of its monitoring role under European Union (Basic Safety Standards for Protection against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations, HIQA has continued engagements in 2021-2023 with the Environmental Health Unit in the Department of Health. Ongoing networking has been facilitated in 2023 with participation at the following events:

- The ESR-led European Commission project EU-JUST-CT (European co-ordinated action on improving justification of computed tomography)
- EU Strategic Agenda for Medical Ionising Radiation Applications (SAMIRA) Study on reporting and learning from patient-related incidents and near misses in radiotherapy, interventional cardiology, nuclear medicine and interventional and diagnostic radiology
- Presenting at the European Radiation Protection Week (ERPW) 2023 conference in Dublin which has a focus on medical applications of ionising

radiation and the associated radiation protection of patients, staff, and the public.

HIQA has continued engagements with the Department of Health in relation to its functions under the Health Act and ongoing preparations to progress the Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Bill 2022 and the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

To advance the new programme of inspection against *the National Standards for Safer Better Healthcare,* the HIQA team published the *Guide to the Assessment Judgment Framework for monitoring healthcare services against the National Standards for Safer Better Healthcare* and a short monitoring guidance which explained the new approach in April 2022. A webinar to support the launch was attended by nearly 300 attendees from the public acute and community healthcare settings.

HIQA presented the new monitoring programme at the conference on *'A Systems Approach to the Clinically Deteriorating Patient'*. This was an in-person conference in June 2022 at the RCSI organised by *The National Deteriorating Patient Recognition & Response Improvement Programme (DPIP).*

A new Memorandum of Understanding was signed between HIQA and the Dental Council in 2023.

8.6 Key publications in Healthcare 2021-2023

Key publications	**Date**
Overview report of lessons learned from receipt of statutory notifications of accidental and unintended exposures 2020[16]	15 Sep 2021
Review of the governance arrangements of gynaecology services at Letterkenny University Hospital	14 Oct 2021
Overview report of lessons learned from receipt of statutory notifications of accidental and unintended exposures 2021	23 Sep 2022
National DRLs for fluoroscopy and fluoroscopically guided interventions	26 Oct 2022
Healthcare Overview Report 2022	14 Dec 2022
Establishing national diagnostic reference levels in radiography, mammography, and dual-energy X-ray absorptiometry services in Ireland and comparing these with European diagnostic reference levels.[17]	28 July 2023

Terms of Reference: Independent statutory review of governance and oversight of processes for surgical implants in Children's Health Ireland [18]	17 Nov 2023
National DRLs for nuclear medicine procedures	17 Nov 2023
National procedures for clinical audit of radiological procedures involving medical exposure to ionising radiation	23 Nov 2023

9. Current and future developments for the Healthcare function in HIQA

With the appointment of the new position of Director of Healthcare Regulation in October 2021, HIQA has worked to develop a new Healthcare Regulation Directorate over the last two years. This new development for HIQA has occurred at a time of wider expansion and change for the Authority, and in parallel with a body of work to define broader changes to HIQA's organisational structure.

While awaiting future expansion of function, the Healthcare Regulation Directorate has formed an interim structure comprising three pillars in order to fulfil current business as follows:

- Healthcare Monitoring – inclusive of medical exposures to ionising radiation regulation
- International Protection Accommodation Services Monitoring (IPAS - formerly referred to as direct provision)
- A Programme Operations Support pillar.

The following sections describes the current and future work on the horizon for the new Healthcare Directorate.

9.1 Monitoring of International Protection Accommodation Services (IPAS)

In 2022, HIQA began preparations to take on an intended new regulatory function of monitoring and inspection of International Protection Accommodation Services (IPAS).

During 2022, HIQA established an IPAS monitoring and inspection pillar within the Healthcare Regulation Directorate. Team members were successfully recruited and completed a significant programme of work to ensure HIQA could carry out this function effectively once enabling legislation is in place.

In order to develop an effective and rights-based approach to inspection and monitoring of accommodation centres, which is focused on improvement, an extensive stakeholder engagement plan was developed and implemented. Over the course of 2022, our team consulted with residents of accommodation centres, other relevant agencies, service providers and non-government organisations as seen in Table 6.

Table 6: Stakeholder engagement by stakeholder and number

DCEDIY	14
External Stakeholder/NGO	40
Service Providers	17
Service Users	18

HIQA collaborated with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) throughout the year on progressing amended regulations to ensure there was awareness of HIQA's needs in respect of a prospective monitoring function.

In order to ensure our inspection approach and methodology was informed by existing expertise across the sector, HIQA established and Expert Advisory Group, which met three times during 2022. Membership of this group included representatives of relevant Government departments, statutory agencies, providers of accommodation centres, and people who had experienced living in these centres.

Common themes related to accommodation centres emerged from this EAG, including safeguarding and protection, assessing and responding to vulnerable residents, the general governance, and the condition of living accommodation.

In December 2022, and with agreement with the DCEDIY, HIQA conducted pilot inspections in three accommodation centres. Each of the three centres were inspected against specified standards which reflected the areas of potential risk identified through our stakeholder engagement process. Immediate findings were forwarded to DCEDIY so that appropriate action could be taken on a national level. Overall summary findings of inspections were presented to the DCEDIY in January 2023, with a view to influencing positive change across accommodation centres on a national basis in the short-term.

The focus of HIQA's IPAS Pillar across 2023 was very much on developing a rapport with service providers. The objective for the year was to prepare the international accommodation sector for being monitored and inspected by HIQA against national standards, and influencing a shift in service provision from one of providing food and accommodation, to a person-centred, rights-based model of working, which is aligned to the national standards.

To encourage sectoral improvements in the short-term, a significant programme of work was undertaken by HIQA in 2023, when our IPAS monitoring team completed a series of on-site workshops for service providers. These workshops informed providers of what it means to be monitored by HIQA, building provider competence in self-assessment against national standards and in the development of quality

improvement plans where areas for improvement are identified. Workshops presented HIQA with the opportunity to guide providers towards prioritising improvements in the three critical areas identified in our pilot inspections. A 'Self-Assessment Questionnaire and Quality Improvement Plan' accompanied by a short video was developed by the IPAS monitoring team to support providers assess their own performance.

A total of 41 on-site workshops were completed and feedback from providers was positive. They indicated that they felt better prepared for monitoring by HIQA and had, or were planning to self-assess against national standards. Furthermore, it was evident from engaging with service providers over the past year that findings of pilot inspections have influenced change in the sector, particularly in areas such as adult safeguarding and risk management systems.

In addition to this programme of work, the IPAS monitoring team maintained its focus on ensuring a rights-based approach to monitoring. In 2023, the team has developed a 'Resident Engagement Strategy', which is informed by the preparatory work undertaken by HIQA in 2022, and in response to our experiences of carrying out pilot inspections. The strategy signifies a stronger partnership between HIQA and people availing of international protection accommodation services and will inform how HIQA will better engage, involve and listen to residents, and embed and value the voice of residents and their experiences in all areas of our work. It aims to strengthen resident participation and engagement during the course of HIQA's monitoring and inspection of international protection accommodation services. Some of the initiatives in this strategy include questionnaires, information leaflets and videos for residents, which have been translated into seven different languages.

Figure 31. Documents created to support IPAS function

During 2023, there were several opportunities for the team to benefit from the experience and expertise of other organisations who have operated within the international protection sector for many years. Several information and training events were held including Cultural Diversity Training with Cultúr Migrant Centre, Human Trafficking and the International Protection Process with the Immigrant Council of Ireland, and on experiences of LGBTQ+ people living in IPAS accommodation centres with LGBT Ireland.

Next steps

At the time of writing, it is expected that the legislation required to allow HIQA to take on this new function will be in place by the end of 2023. Once this happens, HIQA will begin a series of information sessions for providers of accommodation centres, to ensure they know and understand their responsibilities under the amended regulations, the role and requirements of HIQA, and the monitoring process. HIQA will continue to liaise with the DCEDIY on progressing enabling legislation.

9.2 Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Bill 2022

HIQA has continued engagement with the Department of Health on the Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Bill 2022. The Bill has a broad scope and amongst other functions, makes provision for the donation by living persons of their bodies after death for the purposes of anatomical examination or public display, to provide for the establishment of a licensing system in respect of persons undertaking anatomical examinations or public display activities, and to provide that consent is pre-requisite for all procedures involving human organs, tissues and cells. From a HIQA perspective, the bill is intended to mandate HIQA to regulate certain elements of pathology services, for which we will have enforcement powers. The proposed Bill is currently still before the Oireachtas.

9.3 Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

The Patient Safety (Notifiable Incidents and Open Disclosure) Bill 2019 (now enacted as the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023) provides for the mandatory open disclosure, by health services providers of certain incidents occurring in the course of healthcare to patients and their families, amongst other functions. From a HIQA perspective, once commenced, there will be a mandatory requirement on health services providers to notify HIQA (or other relevant regulators) when a notifiable event listed in the Act occurs. In addition, it is expected to extend the application of standards set by the Health Information and Quality

Authority to private hospitals, and extend our monitoring role into these services also.

HIQA has had close engagement with the Department of Health on the progression of this legislation in 2021 - 2023. In particular, HIQA has established a full project team to progress this commencement, with work ongoing across a number of work streams. This represents a very significant commencement for the Directorate. It will increase the number of services we need to monitor, and it also places significant additional workload to manage the patient safety incident notifications submitted by health service providers. This increase in activity will require a reciprocal uplift in resourcing, and we have been in discussions with the Department of Health in relation to this expansion. Further clarity on the commencement of the Act is expected in the coming months.

9.4 Independent statutory review of governance and oversight of processes for surgical implants in Children's Health Ireland

In November 2023, HIQA published the terms of reference for an independent statutory review of the governance and oversight of processes within Children's Health Ireland (CHI) on the use of surgical implants / implantable medical devices, including a focus on the use of non-CE spring implants during spinal surgery in CHI at Temple Street. The terms of reference have been developed following a request by the Minister for Health for HIQA to conduct a review under section 8(1)(c) of the Health Act 2007.

The following terms of reference have been determined for the conduct of this review:

- To make an assessment of the governance, leadership and management arrangements in place within CHI for the use of use of surgical implants / implantable medical devices, including processes around regulatory requirements and notifications, and consideration of the controls and oversight processes.
- To monitor compliance with *the National Standards for Safer Better Healthcare*, in accordance with Section 8(1)(c) of the Health Act 2007 as amended. In doing so, HIQA may use existing information available to it, as relevant.

HIQA's independent statutory review will be conducted in two phases, reviewing compliance at CHI and CHI Temple Street against relevant *National Standards for Safer Better Healthcare*. The scope of the review – as requested of HIQA by the Minister for Health - is to undertake a review, divided in two phases, as follows:

(1) The end-to-end processes around the use of the non-CE spring implants during spinal surgery in Temple Street; and Terms of Reference for the independent statutory review of the governance and oversight of processes within Children's Health Ireland

(2) The controls and oversight processes and governance within CHI on the use of surgical implants / implantable medical devices, including processes around regulatory requirements and notifications. Following completion of the review, a report of the findings and conclusions a will be provided to the Minister for Health and published on www.hiqa.ie.

10. Conclusion

In order to prepare for upcoming changes, HIQA revised its monitoring against the *National Standards for Safer Better Healthcare* to develop a programme which will respond to changing legislation and HIQA's expanding role in healthcare regulation and monitoring. The revised programme is focused on being more agile to respond to risk as identified. The revised programme of monitoring against the *National Standards for Safer Better Healthcare* will ensure HIQA's resilience in a changing healthcare environment. HIQA is committed to promoting a human rights-based approach across healthcare services. This approach is underpinned by the national standards, which place an emphasis on protecting service users' rights, and respecting their autonomy, privacy and dignity. HIQA's programmes will continue to evaluate how healthcare services promote a culture of kindness, consideration and respect for those accessing their system.

In relation to the governance review of gynaecology service at Letterkenny University Hospital, HIQA's findings highlighted the shortfalls in the approach to the governance and oversight of gynaecology services at hospital and hospital-group levels. HIQA was not assured that there were sufficient and effective governance and oversight arrangements in place to assure the quality and safety of gynaecology services, which posed a risk to women using the services. HIQA has been since satisfied that this service has seen significant improvements relative to findings identified in 2021. Notwithstanding this identified improvement trajectory, ongoing monitoring of this service continues to ensure that the improvements are sustained.

Findings from this new programme of inspections in emergency departments in 2022 and 2023 continue to highlight that overcrowding in emergency departments compromises the dignity and respect of patients, and poses a risk to the health and safety of patients. In contrast, overall compliance in wards and clinical areas in hospitals visited by inspectors was generally quite good in 2022 and 2023. While emergency department overcrowding sometimes garners the most attention for understandable reasons, the care that patients receive once admitted to wards is generally positive, and this is echoed by the feedback given by patients to inspectors on the days of inspection.

Many hospitals inspected were working to maintain patient safety on a backdrop of staffing deficits across disciplines when measured against their allocation. Unfilled vacancies at the frontline, and the lack of replacements for short and long-term leave posed challenges for a number of hospitals inspected. This impacted on services provided and the organisations' ability to respond to changes in workload.

HIQA has continued its programme of regulation under its role as the competent authority for medical exposure to ionising radiation. A cross-section of services were inspected in 2021-2023, including publically-funded acute hospitals, private hospitals, standalone private medical imaging facilities and dental services. Under the regulations assessing medical exposure to ionising radiation, HIQA continued a general assessment of the dental sector in 2021-2023. The sector was monitored through onsite inspections, remote inspections and self-assessment questionnaires. Overall high levels of compliance were evident, although there are challenges due to the availability of medical physics experts to service the sector in the context of changing requirements posed by the regulations. HIQA's early findings from this regulatory programme indicate the impact that regulation has to inform positive change.

In summary, our health service continues to seek to address backlogs of care post-pandemic, and for some patients, their condition may have progressed because of the delays they have experienced and services being curtailed.[1] The resilience of our healthcare system was tested to its limits and beyond by the pandemic, and this reinforced the importance of investment in the health service as a key strategic asset for the Irish State.

A resilient health system is one which can anticipate future requirements and transform to meet the needs of the population. The health reform plans in progress in Ireland under Sláintecare, which aims to revise the model of care in Ireland including extending the primary care provision, should provide the catalyst to progress further reforms. Crucial to this plan is the need to maintain and build the healthcare workforce needed to meet growing and changing population. As we move beyond the COVID-19 pandemic, the health system has adapted and responded quickly to the unprecedented disruption to patients and health service pressures over the last number of years. Over the coming years, HIQA is committed to delivering a programme of monitoring and regulation of healthcare services which acts to complement this need to adapt within the health services, in the best interest of patients.

11. Appendices

Appendix 1: Core set of standards assessed as part of routine monitoring in National Standards inspections

Person Centred Care
Standard 1.6 Patient Privacy, Dignity and Autonomy
Standard 1.7 Culture of Kindness, Consideration and Respect
Standard 1.8 Complaints and Concerns are responded to promptly, openly and effectively
Effective Care
Standard 2.7 Physical environment supports high quality, safe and reliable care
Standard 2.8 Effectiveness of healthcare is systematically monitored, evaluated and continuously improved
Safe Care
Standard 3.1 Providers protect patients from the risk of harm through the design of services
Standard 3.3 Providers effectively identify, manage, respond to and report on Patient Safety Incidents
Leadership, Governance and Management
Standard 5.2 Providers have formalised governance arrangements for assurance of high quality, safe and reliable care
Standard 5.5 Providers have effective management arrangements

Standard 5.8 Providers have systematic monitoring arrangements to identify opportunities to continually improve

Workforce

***Standard 6.4** Service providers support their workforce in delivering high quality safe and reliable healthcare

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

This standard was introduced as part of core methodology during 2022 to better assess service providers management of workforce to achieve the high quality, safe and reliable healthcare.

Appendix 2: Inspections conducted against National Standards in acute hospitals and rehabilitation and community inpatient healthcare services in 2022 -2023

Inspections in 2022

Hospital	Resourcing	Date of inspection	Status
St Luke's Hospital Kilkenny (Maternity)	2 day: 4 inspectors	16/02/2022	Report published
The Royal Hospital Donnybrook	2 day: 3 inspectors	21/02/2022	Pilot inspection*
St John's Hospital, Limerick	2 day: 3 inspectors	15/03/2022	Pilot inspection*
University Hospital Limerick (ED)	1 day: 3 inspectors	15/03/2022	Report published
University Hospital Galway	2 day: 4 inspectors	26/04/2022	Pilot inspection*
Midland Regional Hospital Tullamore	2 day: 3 inspectors	26/04/2022	Pilot inspection*
Cork University Hospital (ED)	1 day: 2 inspectors	15/06/2022	Report published
St Columcille's Hospital	2 day: 3 inspectors	22/06/2022	Report published
Cavan and Monaghan Hospital	2 day: 3 inspectors	05/07/2022	Report published
Mayo University Hospital	2 day: 4 inspectors	16/08/2022	Report published
St Michael's Hospital	2 day: 3 inspectors	09/08/2022	Report published
St Vincent's University Hospital	2 day: 4 inspectors	30/08/2022	Report published
University Hospital Kerry	2 day: 4 inspectors	20/09/2022	Report published
Sligo University Hospital (ED)	1 day: 3 inspectors	20/09/2022	Report published
Cork University Maternity Hospital	2 day: 3 inspectors	26/10/2022	Report published
Tallaght University Hospital (ED)	1 day: 4 inspectors	27/10/2022	Report published
Letterkenny University Hospital	2 day: 4 inspectors	16/11/2022	Report published
Naas General Hospital	2 day: 4 inspectors	22/11/2022	Report published

Hospital (cont.)	Resourcing	Date of inspection	Status
Midlands Regional Hospital Mullingar	2 day: 3 inspectors	06/12/2022	Report published
Connolly Hospital	2 day: 3 inspectors	06/12/2022	Report published

Inspections in 2023

Hospital	Resourcing	Date of inspection	Status
St Luke's Hospital Kilkenny	1 day : 3 inspectors	26/01/2023	Report published
Wexford General Hospital (ED)	1 day: 3 inspectors	08/02/2023	Report published
University Hospital Galway (ED)	1 day: 3 inspectors	14/02/2023	Report published
University Hospital Limerick	2 day: 4 inspectors	21/02/2023	Report published
Mallow General Hospital	1 day: 3 inspectors	28/02/2023	Report published
Roscommon University Hospital	1 day: 3 inspectors	02/03/2023	Report published
St Camillus Hospital Rehab/Stroke unit	1 day: 2 inspectors	07/03/2023	Report published
Mercy University Hospital (ED)	1 day: 3 inspectors	09/03/2023	Report published
St James' Hospital Dublin (ED)	1 day: 4 inspectors	29/03/2023	Report published
Midland Regional Hospital Portlaoise	2 day: 3 inspectors	04/04/2023	Report published
Beaumont Hospital (ED)	2 day: 4 inspectors	13/04/2023	Report published
University Hospital Waterford(ED)	1 day: 3 inspectors	18/04/2023	Report published
South Infirmary Victoria University Hospital	1.5 days 3 inspectors	25/04/2023	Report published

Ennis General Hospital	1.5 days 3 inspectors	03/05/2023	Report published
Hospital (cont.)	**Resourcing**	**Date of inspection**	**Status**
Portiuncula University Hospital	2 days :3 inspectors	09/05/2023	Report published
National Maternity Hospital, Holles St	2 days :3 inspectors	30/05/2023	Report published
CHI Temple Street	2 days: 3 inspectors	15/06/2023	Report in draft*
Mayo University Hospital	2 days: 3 inspectors	21/06/2023	Report in draft*
Mater University Hospital (ED)	1 day: 3 inspectors	06/07/2023	Report published
St Mary's Hospital, Phoenix Park	1.5 days 3 inspectors	18/07/2023	Report published
Sligo University Hospital	2 days: 3 inspectors	12/07/2023	Report in draft*
Cork University Hospital	2 days: 5 inspectors	25/07/2023	Report published
St. Mary's Hospital Mullingar	1.5 days 3 inspectors	02/08/2023	Report in draft*
Tipperary University Hospital (ED)	1 day: 2 inspectors	09/08/2023	Report published
Clontarf Hospital	1.5 days 3 inspectors	09/08/2023	Report in draft*
Carlow District Hospital	1.5 days 3 inspectors	15/08/2023	Report in draft*
Rotunda Hospital	2 day 3 inspectors	12/09/2023	Report in draft*
National Rehabilitation Hospital	1.5 days 3 inspectors	13/09/2023	Report in draft*
Belmullet Community Hospital	1.5 days 2 inspectors	19/09/2023	Report in draft*
Nenagh Hospital	1.5 days 3 inspectors	26/09/2023	Report in draft*

Coombe Women and Infants University Hospital	1.5 days 3 inspectors	11/10/2023	Report in draft*
Letterkenny University Hospital	2 days 4 inspectors	07/11/2023	Report in draft*
Hospital (cont.)	**Resourcing**	**Date of inspection**	**Status**
University Hospital Limerick (ED)	1 day: 4 inspectors	21/11/2023	Report in draft*

*Pilot inspections and inspection reports in draft are not included in compliance data considered in this report

Appendix 3: Compliance judgements from each emergency department inspected in hospitals against *National Standards* (NS) in 2022 and 2023

Legend: C= Compliant; SC= Substantially Compliant, PC= Partially Compliant; NC = Non-Compliant

Hospital inspected (U= Unannounced A= Announced)	Year	NS 1.6	NS 3.1	NS 5.5	NS 6.1
Cavan and Monaghan Hospital (A)	2022	SC	SC	SC	C
Connolly Hospital (A)	2022	PC	PC	PC	SC
Cork University Hospital (U)	2022	PC	NC	PC	PC
Letterkenny University Hospital (A)	2022	PC	NC	PC	PC
Mayo University Hospital (A)	2022	NC	NC	PC	NC
Naas General Hospital (A)	2022	NC	NC	PC	PC
Regional Hospital Mullingar (A)	2022	NC	NC	PC	PC
Sligo University Hospital (U)	2022	NC	PC	PC	PC
St Michael's Hospital (A)	2022	C	SC	SC	SC
St Vincent's University Hospital (A)	2022	PC	PC	PC	PC
Tallaght University Hospital (U)	2022	NC	PC	PC	PC
University Hospital Kerry (A)	2022	NC	PC	NC	NC
University Hospital Limerick (U)	2022	NC	NC	PC	NC
Beaumont Hospital (U)	2023	SC	SC	SC	SC
Mater University Hospital	2023	SC	SC	SC	PC

Hospital inspected (U= Unannounced A= Announced)	Year	NS 1.6	NS 3.1	NS 5.5	NS 6.1
Mercy University Hospital (U)	2023	NC	NC	PC	PC
Portiuncula University Hospital (A)	2023	PC	PC	SC	PC
Cork University Hospital (U)	2023	NC	NC	PC	PC
South Tipperary General Hospital	2023	PC	PC	SC	SC
St James' Hospital	2023	PC	PC	PC	PC
St Luke's General Hospital	2023	PC	PC	PC	PC
University Hospital Galway	2023	NC	PC	PC	NC
University Hospital Limerick (U)	2023	NC	PC	PC	PC
University Hospital Waterford	2023	C	SC	C	C
Wexford General Hospital (U)	2023	NC	PC	PC	PC

Appendix 4 Compliance judgements in wards and clinical areas inspected in hospitals against *National Standards* (NS) in 2022 and 2023

Legend: C= Compliant; SC= Substantially Compliant, PC= Partially Compliant; NC = Non-Compliant

Hospital U= Unannounced A= Announced	Year	NS 1.6	NS 1.7	NS 1.8	NS 2.7	NS 2.8	NS 3.1	NS 3.3	NS 5.2	NS 5.5	NS 5.8	NS 6.1	NS 6.4
Cavan and Monaghan Hospital (A)	**2022**	SC	C	SC	SC		PC	C	SC	SC	C		C
Connolly Hospital (A)	**2022**	SC	C	SC	PC	SC	SC	SC	SC	PC	C		
Cork University Maternity Hospital (A)	**2022**	C	C	SC	SC	SC	SC	SC	SC	PC	SC		
Letterkenny University Hospital (A)	**2022**	SC	SC	PC	SC	NC	PC	NC	PC	NC	PC		
Mayo University Hospital (A)	**2022**	SC	C	SC	PC	SC	PC	C	PC	PC	SC		C
Naas General Hospital (A)	**2022**	SC	C	C	PC	SC	SC	SC	SC	SC	C		
Regional Hospital Mullingar (A)	**2022**	SC	SC	SC	PC	PC	PC	PC	PC	PC	PC		

Hospital (cont.) U= Unannounced A= Announced	Year	NS 1.6	NS 1.7	NS 1.8	NS 2.7	NS 2.8	NS 3.1	NS 3.3	NS 5.2	NS 5.5	NS 5.8	NS 6.1	NS 6.4
St Columcille's Hospital (A)	2022	SC	C	SC	PC	SC	SC	SC	PC	PC	PC		C
St Michael's Hospital (A)	2022	SC	C	SC	PC	SC	PC	SC	SC	SC	SC		SC
St Vincent's University Hospital (A)	2022	SC	C	C	PC	SC	SC	SC	C	PC	SC		C
University Hospital Kerry (A)	2022	SC	SC	PC	PC	PC	PC	PC	NC	NC	PC		
Cork University Hospital (A)	2023	PC	C	NC	NC	SC	PC	PC	PC	SC	PC	PC	
Ennis General Hospital (A)	2023	C	C	SC	PC	SC	SC	SC	SC	SC	SC	SC	
Mallow General Hospital (A)	2023	SC	C	SC	PC	SC	SC	C	SC	SC	C	SC	
Midland Regional Hospital Portlaoise (A)	2023	SC	C	SC	PC	SC	PC	C	PC	SC	SC	PC	
National Maternity Hospital (A)	2023	SC	C	C	PC	C	C	C	SC	C	C	PC	

Hospital (cont.) U= Unannounced A= Announced	Year	NS 1.6	NS 1.7	NS 1.8	NS 2.7	NS 2.8	NS 3.1	NS 3.3	NS 5.2	NS 5.5	NS 5.8	NS 6.1	NS 6.4
Portiuncula University Hospital (A)	**2023**	SC	C	SC	NC	SC	PC	SC	SC	SC	SC	SC	
Roscommon University Hospital (A)	**2023**	SC	C	PC	PC	SC	SC	SC	SC	C	C	SC	
South Infirmary Victoria Hospital (A)	**2023**	SC	C	SC	PC	SC	SC	SC	SC	SC	SC	PC	
St Camillus' Hospital (A)	**2023**	PC	C	C	PC	C	SC	C	SC	SC	C	SC	
St Mary's Hospital, Phoenix Park (A)	**2023**	C	C	C	PC	SC	SC	C	SC	SC	SC	PC	
University Hospital Limerick (U)	**2023**	SC	C	SC	NC	PC	SC	SC	SC	SC	SC	PC	

Appendix 5: Case studies relating to ionising radiation incidents to demonstrate effectiveness of actions taken by undertakings

To share learning nationally, HIQA has developed two case studies relating to category 17 notifications to help outline the particular scenario that occurred, the corrective measures put in place by the undertaking, the overall learning and the different risk reduction strategies employed by the undertaking.

Case study 1: General X-ray – equipment
Scenario: While carrying out maintenance on a unit of X-ray equipment, a defect was discovered on the unit's detector. This issue was discovered after a couple of days during routine quality assurance testing on the unit. Several service users had received X-rays with this unit before the issue was discovered and the unit taken out of use. However, the defect was not visible on the images produced. Each service user received less than 1mSv in dose, so individually these incidents were not reportable to HIQA.
Corrective actions taken by undertakings: The detector defect was rectified by service engineers and staff repeating the quality assurance testing. A retrospective audit evaluating all images obtained using the detector was carried out at the imaging facility to determine if the defect resulted in non-diagnostic images that needed repeat exams. No service user needed a repeat exam for any studies performed during the affected period. Several risk reduction strategies to mitigate the risk of re-occurrence of this issue were implemented at the imaging facility. A test is now conducted during maintenance to check if a defect exists on the detector. This issue was raised across multiple forums including with staff, the radiation safety committee, governance committee, and with the servicing company to raise awareness and learning.
Learnings for undertakings: The imaging facility identified multiple non-notifiable incidents of a similar nature which occurred following maintenance of an X-ray unit. While these incidents affected several service users, they did not meet the HIQA threshold for reporting individually. However, they did meet the threshold to be reported as a category 17 incident, which relates to multiple similar non-notifiable incidents which on review

were identified as a potential safety concern for service users. The imaging facility in this instance had a good incident management system in place and carried out trending and analysis to capture incidents of this nature which may be a potential safety concern for service users.

Risk reduction strategies	Effectiveness
➢ simplification and or standardisation	Medium
➢ education and information	Low

Case study 2: CT – optimisation

Scenario:

Over a period of time, radiography staff noticed higher than expected doses from CT exams carried out in a hospital. This was reported to the radiation safety officer who then carried out a review of radiation doses from the most common CT exams. This review revealed that the diagnostic reference levels (DRLs) delivered during those exams were above national and previously established local DRLs.

Corrective actions taken by undertakings:

Medical physics staff and the equipment manufacturer reviewed the findings. During this review, it was noticed that there was a deviation from the standard parameter settings for CT exams. It was discovered that some parameter settings had been manually adjusted by staff attempting to optimise the system. Once discovered, the standard settings were re-programmed and subsequent dose monitoring showed that the doses delivered had returned to normal baseline values. The hospital implemented a number of actions to prevent similar incidents from occurring. For example, access to parameter settings is now password protected, and education and information has been delivered to radiography staff on the impact on doses as a result of parameter setting changes. Also, to more rapidly identify variations from national and local DRLs, automated DRL reports

are generated monthly to supplement information provided by quarterly DRL audits.

Learnings for undertakings:

While the impact of this incident on individual service users did not result in a requirement to notify HIQA, it was positive that the hospital identified the trend in incidents and reported these as a category 17 incident to HIQA. The increased awareness of staff and education provided in relation to doses delivered during procedures serve to improve the protection and safety of service users undergoing medical exposures to ionising radiation.

Risk reduction strategies	Effectiveness
➢ forcing functions	High
➢ reminders, checklists and double checks	Medium
➢ education and information	Low

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