Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Linking learning to National Standards

How recommendations from previous HIQA investigation, statutory inquiry and review reports (2009–2015) relate to specific National Standards for Safer Better Healthcare

June 2015

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high-quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.
- **Supporting Improvement** – Supporting health and social care services to implement standards by providing education in quality improvement tools and methodologies.
- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.
- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Contents

1. Executive summary

Since its foundation in 2007, the Health Information and Quality Authority (the Authority, or HIQA) has produced a substantial amount of recommendations and learning for public hospitals in Ireland through its various investigations and other regulatory work. This document communicates some of this learning to support public hospitals to implement the *National Standards for Safer Better Healthcare*. This has been done by relating these recommendations to an overarching Standard in the *National Standards for Safer Better Healthcare*.

It is internationally recognised that setting, implementing and monitoring compliance with standards are important factors in making improvements in quality and safety in healthcare. The *National Standards for Safer Better Healthcare* (the National Standards), mandated by the Minister for Health and published in 2012, describe a vision for high-quality, safe healthcare by promoting healthcare that is up to date, effective, consistent and in line with national and international best available evidence.

To date, the Authority has completed seven investigations, a statutory inquiry and three reviews into the quality and safety of services delivered by public healthcare providers in Ireland (from 2007 to 2015), and published reports of each regulatory process between 2008 and 2015. Each report detailed relevant local, regional and national recommendations. These findings and recommendations are intended to be used by all healthcare services to inform and improve practice.

This document connects each recommendation in seven of these HIQA reports with a corresponding and overarching National Standard. This is done to generate an awareness of how the National Standards relate to real-world care delivery. It also identifies that recommendations are repeatedly linked to the same Standards. When reviewing these in their totality, a number of common issues emerge in relation to services provided in public acute hospitals. These issues require uniform implementation across the system. Cumulative findings require acute hospitals to ensure that:

- the model of service is well planned, clearly articulated and fully understood by all those involved in providing that service, so that care delivery is:
  - integrated, efficient and reliable
- there is effective corporate and clinical governance
- care provided is evidence-based

- the quality and safety of care provided is effectively monitored
- where services fail to meet the desired standard, and an investigation occurs, that learning generated from this process is effectively shared and recommendations enacted.

High-quality, safe healthcare is delivered through models of service that are well articulated and supported by good governance structures. The delivery of care is based on best available evidence, while performance is monitored continuously to determine if a service meets National Standards. When things go wrong or desired outcomes are not achieved, there are systems in place to collect, analyse, investigate and learn so that care is improved and in as far as possible mistakes are not repeated. Any learning and recommendations following the investigation of adverse events are shared within and across services to drive improvements in quality and safety for all patients.

In implementing the recommendations of investigation, statutory inquiry and review reports, it is important for each service provider to look at the National Standard or Standards associated with the recommendation to ensure their service meets the particular National Standard.

2. Monitoring and regulation of healthcare

Healthcare is a high-risk area and despite the best efforts of people working in it, risk cannot be eliminated entirely. However, those responsible for planning, resourcing, managing and delivering healthcare have a duty to protect patients and service users as far as reasonably practicable from the risk of harm. This includes taking measures to avoid any unnecessary risk and creating a culture of learning from patient-safety incidents.

Regulation of healthcare aims to ensure, as far as possible, that patients and service users receive the highest possible quality of care by monitoring services against evidence-based standards of care. It is internationally recognised that setting, implementing and monitoring compliance with standards are important factors in making improvements in quality and safety in healthcare.[(1)] Standards help to provide a consistent approach to quality and safety which can be applied across a variety of health and social care services. Standards use evidence-based improvement strategies to manage the gaps between current and best practice outcomes for patients and service users.

3. National Standards for Safer Better Healthcare

The *National Standards for Safer Better Healthcare*, mandated by the Minister for Health and published in 2012, describe a vision for high-quality, safe healthcare by promoting healthcare that is up to date, effective, consistent and in line with national and international best available evidence.[(2)] The primary aims of the National Standards are to:

- protect patients from harm
- improve the quality of health services
- provide an assurance mechanism for healthcare service providers to check if they have relevant systems in place to ensure quality and safety standards are met
- provide a quality improvement framework that assists health service providers to reach improvement goals.

The National Standards have been designed so that they can be implemented at all levels of the healthcare organisation. This includes all healthcare services, settings and locations (excluding mental health services, which is outside the Authority's legal remit) provided or funded by the Health Service Executive (HSE). These include but are not limited to hospital care, ambulance services, community care and primary care.

The *National Standards for Safer Better Healthcare* contain 45 Standards presented under **eight themes**. Collectively, these National Standards describe how a service provides high-quality, safe and reliable healthcare which is centred on the service user.

Themes one to four of the National Standards describe the dimensions of quality and safety in the delivery of a person-centred healthcare service. They are:

- Theme 1: Person-centred Care and Support
- Theme 2: Effective Care and Support
- Theme 3: Safe Care and Support
- Theme 4: Better Health and Wellbeing.

To deliver high-quality, safe and person-centred care that promotes the individual's health and wellbeing, there needs to be certain capacity and capability factors in place to ensure the sustainability of the service.

Themes five to eight of the National Standards describe the capacity and capability factors necessary to deliver high-quality safe care. They are:

- Theme 5: Leadership, Governance and Management
- Theme 6: Workforce
- Theme 7: Use of Resources
- Theme 8: Use of Information.

4. Implementation of recommendations and the *National Standards for Safer Better Healthcare*

To date, the Authority has completed seven investigations, one statutory inquiry, and three reviews into the quality and safety of services delivered by public healthcare providers in Ireland (from 2008 to 2015).[3,4,5,6,7,8,9,10,11,12,13] The investigations, statutory inquiry and reviews were conducted in a wide variety of settings and services and the resulting recommendations relate to specific areas of concern to the safety, quality and standards of those services.

Each investigation, review and the statutory inquiry followed clear terms of reference. Investigations and reviews completed following the publication of the *National Standards for Safer Better Healthcare* in 2012 were aligned to the relevant *National Standards for Safer Better Healthcare*. As part of the investigation or review process, lines of enquiry were developed to determine what sources of evidence

were required to allow for an assessment of compliance with these National Standards. The recommendations from investigations and other review or inquiry processes carried out prior to the publication of the *National Standards for Safer Better Healthcare* were aligned with the relevant National Standard to provide clarity to service providers on applying and implementing the National Standards. Each regulatory process culminated in a published report detailing the findings of the investigation, review or inquiry team.

A number of lines of enquiry (and associated National Standards) could lead to one overall recommendation. However, to assist service providers in implementing recommendations from the reports, this document identifies and relates the most relevant overarching National Standard in the *National Standards for Safer Better Healthcare* with each recommendation from the various HIQA reports published between 2009 and 2015 which have been analysed in this document.

Service providers are required to review recommendations made in reports, and determine the relevance of these recommendations to their service. A key factor in this process involves service providers assessing their service against not only the relevant recommendation but also the National Standard or Standards relating to that recommendation. For example, a number of recommendations, which were made in relation to maternity services, also apply to all healthcare providers.

In reviewing the recommendations from national reports, service providers should look at the National Standard or Standards connected with each recommendation to ultimately determine if their service meets the requirements of the *National Standard for Safer Better Healthcare*. In this context, implementing recommendations can be at a microsystem level (department or directorate level), mesosystem level (hospital or specific service) or macrosystem level (hospital group or national healthcare service level).

The Authority has seen in its various national reports that many improvements to patient safety do not involve additional financial resources. Rather, they involve commitment of competent individuals to planning, managing and working in the service to ensure effective safe practices. It is recognised that all individuals working in healthcare can improve patient safety by engaging with patients and their families, learning from errors, sharing the learning across the service and communicating effectively within and across the healthcare team.

Understanding all of the contributory issues that lead to errors is fundamental for considering the changes that need to be put in place to try to prevent the same errors being repeated.

5. Relating recommendations from national investigation, statutory inquiry and review reports to the *National Standards for Safer Better Healthcare*

This document relates 232 recommendations made by the Authority in seven of its reports (five investigation reports, a statutory inquiry report, and one review report of healthcare services) to the *National Standards for Safer Better Healthcare* to identify reoccurring issues (see Appendix 1). Two HIQA investigations and two reviews were excluded for the following reasons:

- The two investigations and subsequent national review report relating to national symptomatic breast disease services were not included in this document as these services were monitored against the *National Quality Assurance Standards for Symptomatic Breast Disease Services*.
- The *Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals* culminated in the identification of risks requiring action by the service provider rather than recommendations. While not included in this analysis, but to support service providers, the risks identified in the UL Hospitals report were connected with one overarching National Standard, which is set out in a separate section at the end of this document.

The following table (Table 1) sets out the 232 recommendations in the seven reports used in this analysis and details which overarching National Standard has been aligned to each recommendation. A number of the HIQA reports targeted their recommendations at different service levels, which is noted in the table by the use of the following capital letters before the recommendation number:

- N = national
- L = local
- SOC = systems of care
- G = governance*
- PCC = person-centred care
- SC = safe care.

* The 2012 HIQA report into services at The Adelaide and Meath Hospital, Dublin, Incorporating the National Children's Hospital did not use sequential numbering for recommendations. To avoid confusion, recommendations that were defined in the report as local (highlighted in green in the original 2012 report) are listed from L1 to L5 and the numbering of national recommendations (highlighted in blue in the 2012 report) are listed as N3 to N71 (total of 76 recommendations).

For the purpose of this table, the full title of reports are shortened as follows (note some hospital names have changed since the HIQA reports were first published):

- Ennis General Hospital (Ennis)
- Mallow General Hospital (Mallow)
- Inter-agency arrangements in place for people requiring emergency transportation for transplant surgery (ETT)
- The Adelaide and Meath Hospital, Dublin, Incorporating the National Children's Hospital (AMNCH)
- University Hospital Galway (UHG)
- Pre-hospital emergency care (PHEC)
- Midland Regional Hospital, Portlaoise (Portlaoise).

Details of the full titles of the reports are listed in the references at the end of this document.

Table 1: Relating recommendations from HIQA investigation, statutory inquiry and review reports to the *National Standards for Safer Better Healthcare*

National Standards for Safer Better Healthcare		Ennis	Mallow	ETT	AMNCH	UHG	PHEC	Portlaoise
Theme 1	**Person-centred Care**							
Standard 1.1	The planning, design and delivery of services are informed by service users' identified needs and preferences.							1
Standard 1.2	Service users have equitable access to healthcare services based on their assessed needs.				N26			
Standard 1.4	Service users are enabled to participate in making informed decisions about their care.	L3.2 N3.4		PCC1 PCC2 PCC3			N8	
Standard 1.8	Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this	L12.3 L12.6 N12.7 N12.9						

	process.							
Theme 2	**Effective Care**							
Standard 2.1	Healthcare reflects national and international evidence of what is known to achieve best outcomes for service users.	N2.5 N2.7 N5.5 N10.3	SOC2 SOC7		N7 N8 N14	L10 L11 N9 N10 N11 N12 N13		
Standard 2.2	Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.	L3.1 N9.3			N23	L6 L9 N14		
Standard 2.3	Service users receive integrated care which is coordinated effectively within and between services.	L4.3 L5.2 L5.3 L8.3 L9.1	SOC3 SOC5	G1	L3 N9 N18 N20 N21 N24			
Standard 2.4	An identified healthcare professional has overall responsibility and accountability for a service user's care during an				N11			

	episode of care.							
Standard 2.5	All information necessary to support the provision of effective care, including information provided by the service user, is available at the point of clinical decision-making.	L8.4				L8		
Standard 2.6	Care is provided through a model of service designed to deliver high-quality, safe and reliable healthcare.	L1.1 L1.2 L1.3 N1.4 L2.2 L2.3 L4.1 L4.2 N5.4 L6.1 L6.2 L6.3 N6.4 N9.4	SOC1 SOC4 SOC8		L1	N7 N8	N5	3
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				N3	L7		

	service users.							
Standard 2.8	The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	N2.6 L3.3 N5.6 L7.2 L7.3 L8.2 L10.1 L10.2	SOC9	G10	N4 N5 N15 N16 N17 N19			
Theme 3	**Safe Care**							
Standard 3.1	Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	L4.4 N4.5		SC1 SC2				
Standard 3.2	Service providers monitor and learn from information relevant to the provision of safe services and actively promote learning both internally and externally.				N51	L14 N15		8
Standard 3.5	Service providers fully and openly inform and support service users as soon as possible after an adverse event		G8					

	affecting them has occurred, or becomes known, and continue to provide information and support as needed.							
Theme 5	**Leadership, Governance and Management**							
Standard 5.1	Service providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.	L11.2 L11.7		G11	N42 N46 N47 N53 N55 N61	N4		
Standard 5.2	Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	L8.1 L11.1 L11.3 L11.4 L11.5 L11.6 L12.4 L13.3	G2 G7	G2	L6 L7 N30 N32 N35 N36 N40 N48 N66 N67 N69	L3 N2 N3	N2 N3 N10 N12	4

Standard 5.3	Service providers maintain a publicly available statement of purpose that accurately describes the services provided, including how and where they are provided.	L5.1	G1					
Standard 5.4	Service providers set clear objectives and develop a clear plan for delivering high-quality, safe and reliable healthcare services.				N44 N56 N57 N63 N64 N65			
Standard 5.5	Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	L2.1 L7.1 L13.1 L13.2	G5 G6	G4 G5 G9	L2 N22 N70		N4 N11	
Standard 5.6	Leaders at all levels promote and strengthen a culture of quality and safety throughout the service.		G4		N43	N6		6
Standard 5.7	Members of the workforce at all levels are enabled to exercise their personal and professional responsibility for the quality and safety of services provided.				N41 N50	L2		

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.	L12.1 L12.2 L12.5	SOC6 G3	G7 G8	N25 L4 L5 N27 N45 N68		N7	
Standard 5.9	The quality and safety of services provided on behalf of healthcare service providers are monitored through formalised agreements.			G3				
Standard 5.10	The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.				N28			
Standard 5.11	Service providers act on standards and alerts, and take into account recommendations and guidance, as formally issued by relevant regulatory bodies as they apply to their service.	N12.8 N13.4 N13.5	G9 G10	G12	N29 N31 N33 N52 N71	L1 L4 L5 N1 N5	N1	2 7
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.	L9.2			N6 N10 N12		N6	

Standard 6.2	Service providers recruit people with the required competencies to provide high-quality, safe and reliable healthcare.				N34 N37 N59 N60			5
Standard 6.3	Service providers ensure their workforce have the competencies required to deliver high-quality, safe and reliable healthcare.	N2.4	SOC10		N13 N38 N49 N62	L12 L13		
Standard 6.4	Service providers support their workforce in delivering high-quality, safe and reliable healthcare.				N39 N54 N58		N9	
Theme 8	**Use of Information**							
Standard 8.1	Service providers use information as a resource in planning, delivering, managing and improving the quality, safety and reliability of healthcare.			G6		N16 N17 N18 N19		
Standard 8.3	Service providers have effective arrangements for the management of healthcare records.					L15		
	Total	**65**	**20**	**17**	**76**	**34**	**12**	**8**

6. Findings

The 232 recommendations in the seven reports, published by the Authority between 2009 and 2015, were linked to 32 of the 45 *National Standards for Safer Better Healthcare*. The top 10 most frequently occurring National Standards which relate to recommendations are shown in Figure 1 on the following page.

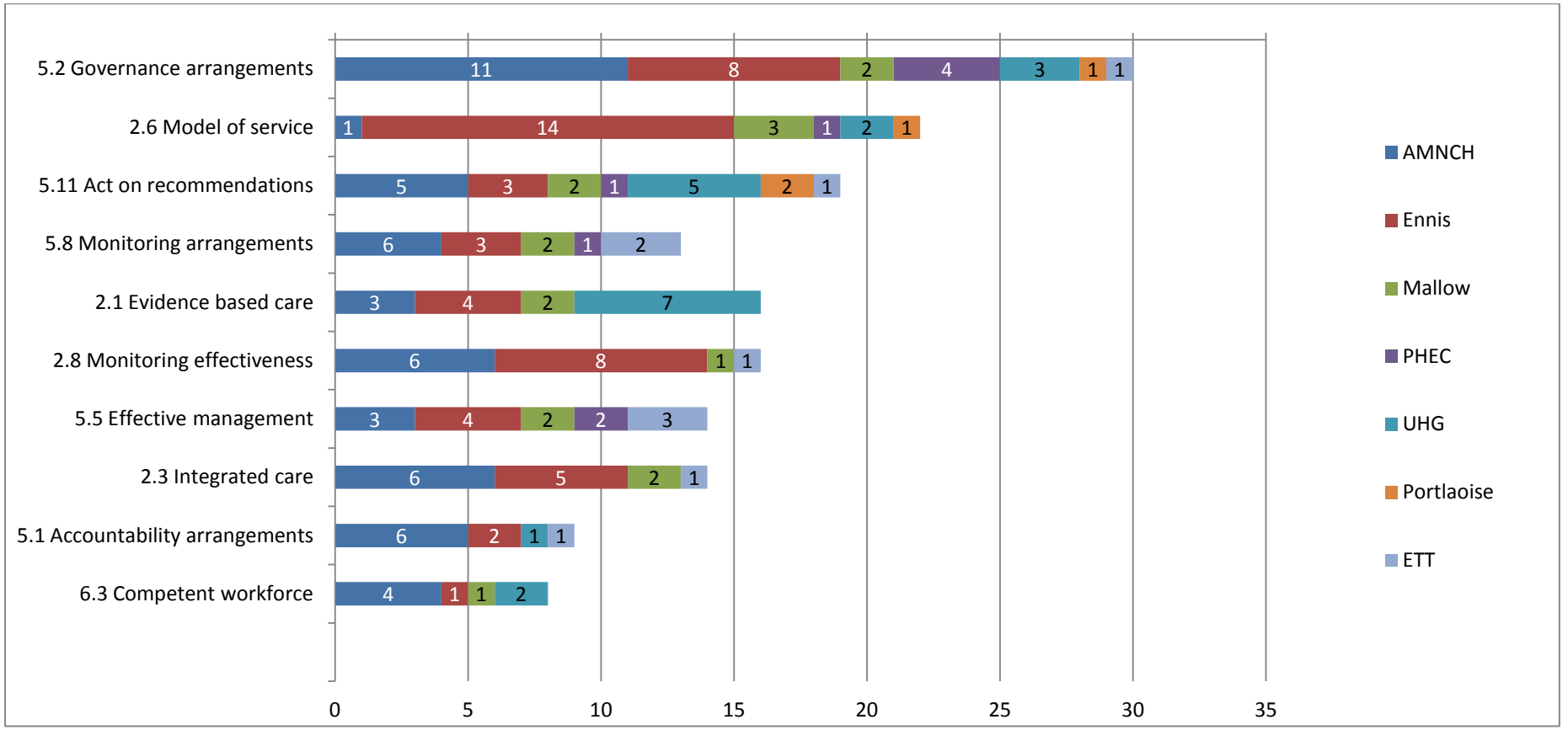
Before drawing conclusions, it is important to be aware of the limitations of such an analysis. Findings and recommendations identified in the investigation, statutory inquiry and review reports related mainly to the three themes of Effective Care and Support; Leadership, Governance and Management; and Workforce. This was primarily because the investigations, inquiry and reviews focused on the systems in place to deliver high-quality, safe care rather than the patient experience, which would be more likely to be reflected in National Standards under other themes. This does not take from the importance of the other Standards under the themes of Person-centred Care and Support; Safe Care and Support; Better Health and Wellbeing; Use of Resources; and Use of Information.

The number of recommendations in recently published investigation and review reports has been decreased by the Authority. The reason for this reduction is to put a stronger focus on the important issues that arise from findings and to help service providers concentrate on implementing key recommendations that would lead to improved safety and quality of care for patients.

Relating the recommendations with *National Standards for Safer Better Healthcare* identified that recommendations are repeatedly associated with the same National Standards.

When reviewing these in their totality, a number of common issues emerge that reflect important areas in healthcare where further development and guidance is required to ensure the delivery of a high-quality, safe, and reliable service for all. These key issues are detailed in Table 2.

Figure 1: *National Standards for Safer Better Healthcare* which were attributed to recommendations in four or more investigation, statutory inquiry or review reports



Key to Figure 1: the figure above highlights the National Standard with the most recommendations connected to it. The most frequenly occurring National Standard was Standard 5.2. which related to 30 recommendations in total (11 recommendations in the AMNCH report, eight in the Ennis report, two in the Mallow report and so on).

Table 2. Common issues emerging from an analysis of the HIQA recommendations relating to the *National Standards for Safer Better Healthcare*

Issues	National Standard	Number of recommendations	% of total recommendations (n=232)
Designing the model of service to deliver integrated care	2.3 Integrated care	14	6%
	2.6 Model of service	22	9%
Effective corporate and clinical governance	5.1 Accountability arrangements	10	4%
	5.2 Governance arrangements	30	13%
	5.5 Effective management	14	6%
	6.3 Competent workforce	8	3%
Care provided is evidence based	2.1 Evidence-based care	16	7%
Monitoring the effectiveness of care	5.8 Monitoring arrangements	14	6%
	2.8 Monitoring effectiveness	16	7%
Acting on recommend-ations	5.11 Act on recommendations	19	8%

6.1 Designing the model of service to deliver integrated care

A model of service sets out the way a health service is delivered and the term can be applied to a single service unit, to an organisation or to a national service. It should be developed using an evidence-based process, agreed through the service's governance structures and reflecting the service's statement of purpose (a statement of purpose is a document that describes the service provider, the type of service provided and the people for whom the service is provided).[2] Models of service reflect best available evidence, comply with relevant legislation and also take into account the service's available resources. Service providers identify the processes required to deliver the model of service that they have defined for their service. They align their resources, including their workforce, to perform those processes reliably, and these processes are regularly reviewed and updated in line with best available evidence and the model of the service.[14]

The provision and coordination of care can be complex. Patients may receive care from more than one practitioner, team or service provider and may have their care shared across services. As a result, it is essential that an identified healthcare professional is accountable and responsible for the coordination of a patient's care at all times. To ensure the safe and effective management of care for a patient, an integrated approach which works in partnership with the patient from referral through to discharge home or to community services is needed. The HSE National Clinical Care Programmes were established with the aim of improving and standardising patient care, bringing together clinical specialities and enabling them to share innovative ways of delivering greater benefits for patients.[15] The establishment of hospital groups as a transition to independent hospital trusts aims to allow appropriate integration and improve patient flow across the continuum of care.[14]

There were 22 recommendations in all seven reports relating to Standard 2.6. This Standard refers to the importance of providing care through a model of service that has been designed to deliver high-quality, safe and reliable healthcare (this represented 9% of all 232 recommendations). There were 14 recommendations relating to Standard 2.3 which refers to the importance of integrated care.

Theme 2 – Effective Care and Support	
Standard 2.3	Service users receive integrated care which is coordinated effectively within and between services.
Standard 2.6	Care is provided through a model of service designed to deliver high-quality, safe and reliable healthcare.

6.2 Effective corporate and clinical governance

Governance in healthcare includes the systems, processes, and behaviours by which services lead, direct and control their functions in order to achieve their objectives. This includes ensuring the quality and safety of services for service users.[2]

Evidence suggests that there is significant correlation between an effective governance system in a health service organisation and the level of performance achieved within that organisation.[15] Good governance should be participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive, and should follow the rule of law.[15] When the necessary capacity and capability factors are in place, the service is better placed to provide safe, effective, person-centred care that promotes better health to those using it. One of the key principles of good governance in healthcare is accountability. There are clear lines of accountability at individual, team and system levels in healthcare, with service providers held accountable to employers, professional bodies and the public. Accountability is a complex concept in healthcare and is recognised as a key driver for safety and quality.[1]

A health service meeting the *National Standards for Safer Better Healthcare* has clear accountability, good management and a well-organised, skilled and competent workforce. It makes the best use of resources and information available to it.

Governance arrangements across the healthcare system should enable a connected and integrated approach at local, regional and national levels ensuring good governance is in place, and that learning occurs and is disseminated effectively. The establishment of hospital groups as a transition to independent hospital trusts potentially supports an integrated governance structure, maximising the strengths of both larger and smaller hospitals to deliver the best outcomes of care for service users.[16]

There were 10 recommendations in relation to Standard 5.1 and 30 recommendations in all seven reports relating to Standard 5.2. Standards 5.1 and 5.2 refer to the need for formalised accountability and governance arrangements. There were 14 recommendations relating to Standard 5.5 on management arrangements and eight linked to workforce Standard 6.3.

Theme 5 – Leadership, Governance and Management	
Standard 5.1	Service providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.

Standard 5.2	Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.
Standard 5.5	Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.
Theme 6 - Workforce	
Standard 6.3	Service providers ensure their workforce have the competencies required to deliver high-quality, safe and reliable healthcare.

6.3 Care provided is evidence based

Evidence-based healthcare involves integrating the best available evidence from systematic research, healthcare professionals' knowledge and experience, and service users' individual values and circumstances. It seeks to assess the quality of evidence on the risks and benefits of healthcare delivery and therefore is as relevant to managers and policy makers as it is to front-line healthcare professionals.[14] Healthcare that is supported by best available evidence helps assure providers that they are delivering high-quality, safe and reliable care.

In Ireland, the National Clinical Effectiveness Committee[17] has responsibility for the development and quality assurance of a national suite of clinical guidelines for use in all relevant services.

There were 16 recommendations in four of the seven reports relating to Standard 2.1.

Theme 2 – Effective Care and Support	
Standard 2.1	Healthcare reflects national and international evidence of what is known to achieve best outcomes for service users.

6.4 Monitoring the effectiveness of care

Performance monitoring in healthcare is a continuous process that involves collecting data to determine if a service is meeting desired standards or targets. It helps to identify what is working and what needs improvement, allowing the service to build

upon existing good practice and improve under-performing aspects of care, in turn benefiting all current and future patients.

Performance monitoring in healthcare requires good quality information. This can only be achieved by having a systematic process to ensure that data is collected consistently, both within, and between organisations. Examples of tools used to monitor performance include key performance indicators (KPIs) and audits.[14]

Clinical audits are designed to measure and improve the quality of patient care, investigate measures of outcomes and compare findings across organisations and patient groups.[1] Conducting and participating in local and national audit programmes aims to improve the quality of care by helping to identify and promote good practice. This can lead to improvements in service delivery and outcomes for patients at all levels. Reporting publicly on quality and safety programmes and their findings allows service providers to share learning within the service, across the service and with service users.[14]

There were 16 recommendations relating to Standard 2.8 and 14 recommendations relating to Standard 5.8.

Theme 2 – Effective Care and Support	
Standard 2.8	The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Theme 5 Leadership, Governance and Management	
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.

6.5 Acting on recommendations

To improve patient safety, healthcare organisations and systems must learn from mistakes. The importance of sharing recommendations and actions after an investigation is crucial if lessons are to be learnt and the quality and safety of patient care is to be improved.[18-19] A consequence of not sharing may mean that the same mistakes occur repeatedly in many settings and patients continue to be harmed by preventable errors.[19]

Information relevant to providing safe services comes from a variety of sources including:

- recommendations following investigations and reviews
- findings from risk assessments
- patient-safety incidents
- complaints, concerns and compliments
- audits
- service-user satisfaction or experience surveys.

It is important that service providers are able to analyse all information relevant to the provision of safe services. This facilitates the identification of trends or patterns in the information, such as risks to service users, and proactively highlights opportunities for improvement in service design or delivery.[14]

A recent study identified continuity of management as a key factor in the successful implementation of recommendations following an investigation into the quality and safety of care.[20] A possible solution suggested to address this issue involved organisations developing a culture of continuous learning following the investigation of adverse events – so that organisations become less exposed to loss of corporate memory when experienced people leave an organisation.[20]

There were 19 recommendations in all seven reports relating to this Standard.

Theme 5 – Leadership, Governance and Management	
Standard 5.11	Service providers act on standards and alerts, and take into account recommendations and guidance, as formally issued by relevant regulatory bodies as they apply to their service.

7. Relating risks identified in the *Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals* to the *National Standards for Safer Better Healthcare*

The *Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals*, which was published in 2014, identified a number of risks requiring action by University of Limerick Hospitals and the Health Service Executive (HSE) nationally. The approach adopted in this review process was to identify risks requiring action by the service at a local and national level, and to support services in driving improvements in the quality and safety of care.

As part of this current analysis, the risks identified were connected to one overarching National Standard and broadly corresponded to the findings described in this document. See Table 3.

Table 3: Relating risks identified in the *Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals* to the *National Standard for Safer Better Healthcare*

Theme 2	**Effective Care and Support**	
Standard 2.1	Healthcare reflects national and international evidence of what is known to achieve best outcomes for service users.	R8
Standard 2.2	Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.	R5
Standard 2.3	Service users receive integrated care which is coordinated effectively within and between services.	R11
Standard 2.5	All information necessary to support the provision of effective care, including information provided by the service user, is available at the point of clinical decision making.	R7

Standard 2.6	Care is provided through a model of service designed to deliver high quality, safe and reliable healthcare.	R2
Standard 2.8	The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	R3
Theme 5	**Leadership, Governance and Management**	
Standard 5.1	Service providers have clear accountability arrangements to achieve the delivery of high quality, safe and reliable healthcare.	R4, R9, R10
Standard 5.5	Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	R1
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.	R6, R12

8. Conclusion

A patient's healthcare experience is determined by the care they receive from front-line staff. The safe and effective delivery of care by front-line staff is overseen by effective leaders within a good organisational governance structure.

High-quality, safe and reliable healthcare is delivered through models of service that are well articulated and supported by good governance structures. The delivery of care is based on best available evidence and performance is monitored continuously to determine if a service meets National Standards. When things go wrong or desired outcomes are not achieved, there needs to be systems in place to collect, analyse, investigate and learn so that care is improved and mistakes are not repeated. Any learning and recommendations following the investigation of adverse events are shared within and across services to drive improvements in quality and safety for all patients. It is recognised internationally that setting standards and measuring compliance with them can accelerate the drive towards a high-quality, safe and reliable service for all.

In implementing the recommendations of investigation, statutory inquiry and review reports, it is important for each service provider to look at the National Standard or Standards associated with the recommendation to ensure their service meets the particular National Standard.

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Appendix 1 – Investigation, statutory inquiry and review reports included and excluded in the analysis

In scope

The investigation, statutory inquiry and review reports included in this paper are as follows:

Investigations 2009 – 2015

1. **Portlaoise** – Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise (2015).

2. **UHG** - Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration and as reflected in the care and treatment provided to Savita Halappanavar (2013).

3. **AMNCH** - Investigation into the quality and safety of services and supporting arrangements provided to patients requiring acute admission and receiving care in the Emergency Department of the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH) (2012).

4. **Mallow** - Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at Mallow General Hospital (2011).

5. **Ennis** - Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at the Mid-Western Regional Hospital Ennis (2009).

Statutory Inquiry 2011

1. **ETT** - Health Information and Quality Authority. Report of the Inquiry into the circumstances that led to the failed transportation of Meadhbh McGivern for transplant surgery and the existing inter-agency arrangements in place for people requiring emergency transportation for transplant surgery (2011).

Review 2014

1. **PHEC** -Review of pre-hospital emergency care services to ensure high quality in the assessment, diagnosis, clinical management and transporting of acutely ill patients to appropriate healthcare facilities (2014).

Out of scope

The following two investigation reports and two review reports were considered outside the scope of this review for reasons explained below:

Investigations 2008

1. Investigation Report into the Pathology Service and the Symptomatic Breast Disease Service at University Hospital Galway (2008).
2. Investigation Report into the care received by Rebecca O'Malley, Symptomatic Breast Disease Services at the Mid Western Regional Hospital Limerick and the Pathology Services at Cork University Hospital (2008).

Review 2010

1. Report of the National Quality Review of Symptomatic Breast Disease Services in Ireland (2010).

Review 2014

1. **ULH** - Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals (2014).

These investigation reports were excluded from the mapping process as the *Report of the National Quality Review of Symptomatic Breast Disease Services in Ireland,* published in 2010 by the Authority, addressed the recommendations from both these investigations in its findings and recommendations. The 2010 *Report of the National Quality Review of Symptomatic Breast Disease Services in Ireland* was excluded as services were monitored against the *National Quality Assurance Standards for Symptomatic Breast Disease Services.*

The review at University Hospital Limerick '*Report of the review of the governance arrangements as reflected in the safety, quality and standards of services at UL Hospitals'* detailed identified risks and did not make specific recommendations so was excluded from the analysis. A separate section in the body of this current document connects these risks to a corresponding and overarching National Standard.

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