



HIQA's Monitoring Programme against the *National Standards for Safer Better Healthcare* (NSSBH)

'The Deteriorating Patient & The Assessment Judgement Framework'

14 June 2022

Aims

- Outline HIQA's monitoring programme
- Explain HIQA's focus on the deteriorating patient



Objectives

- Outline HIQA's approach to monitoring to date
- Identify key drivers for change
- Refer to the Guidance to the assessment Judgment Framework doc (published in April 2022) in relation to the DPIP



Monitoring approach against National Standards in Healthcare since 2012

PROACTIVE

Thematic monitoring against National Standards

Infection Prevention & Control, Medication Safety, Antimicrobial Stewardship, Nutrition and Hydration, Maternity.

PROACTIVE / REACTIVE

Governance/Assurance Reviews

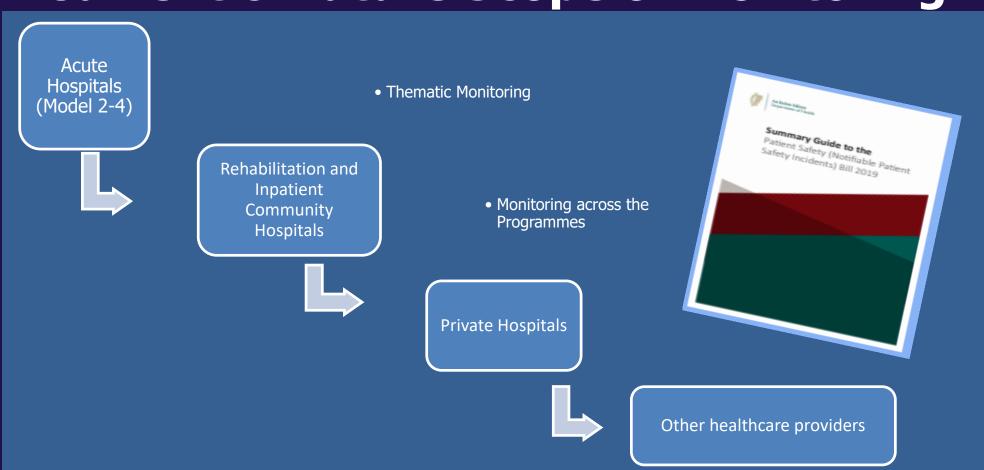
Ambulance services, University Hospital Limerick Review,

Follow-up assurance reviews at Midland Regional Hospital Portlaoise, Ambulance services,

REACTIVE

Section 9 Statutory Investigations

Current & Future Scope of Monitoring



Benefits of new monitoring approach?

INCREASE AGILITY

Monitoring Compliance Postpandemic New **ADAPT** to new and expanded role

Patient Safety Bill, Slaintecare

New Monitoring
Approach of
National
Standards

INTEGRATE: HIQA's new ICT system (PRISM)

PREPARE for Licensing

Challenges & Response to Change

Challenges – Patient Safety Bill - short notice inspection broad range of risk areas

Response – An assessment judgement framework against the 45 *National Standards for Safer Better Healthcare* - ready for use across bespoke range of risk inspections

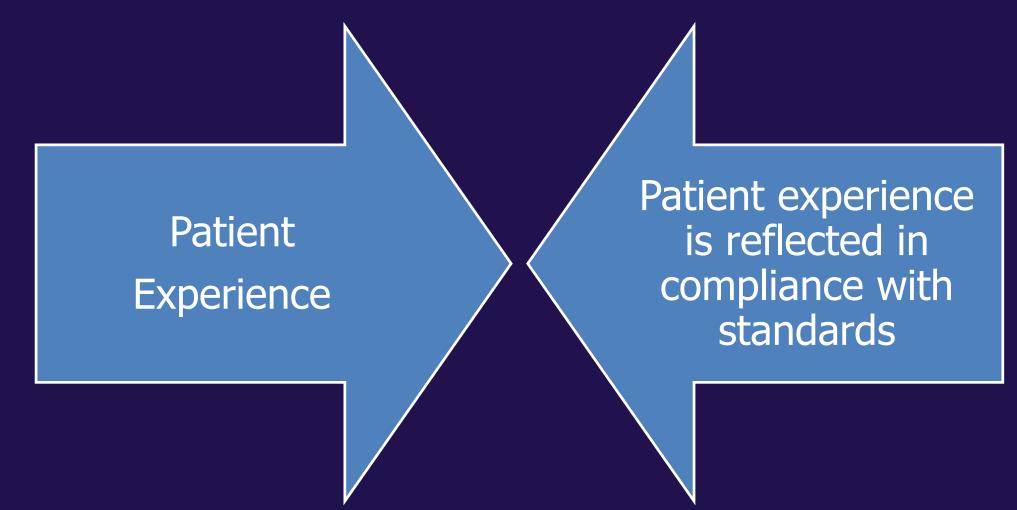
Challenges – Previous inspection types – would not be transferrable across different settings

Response – A core
 assessment against the
 *National Standards for Safer
 Better Healthcare -* builds on
 prior work, pulls in new areas
 of focus - applicable across
 any healthcare setting (inc.
 private sector)

Challenge – Conducting multiple parallel thematic monitoring programmes is not scalable

 Response – a single inspection approach will be applied at scale on a regional basis

Balance patient experience with compliance with standards



Assessment of Core Set of Standards: what is involved?



5 Themes: 11 Standards

- ➤ PCC Human Rights Based approach –
 Surveys National Care Experience Programme
 ➤ Effective Care, evidence based and
- monitored
- ➤ Safe Care (protecting patients from harm) focus on 4 key risk areas
 - ▶1. Infection Prevention & Control
 - ▶2. Medication Safety
 - >3. Transitions of care
 - ▶4. Deteriorating patient inc EWS & Sepsis
- ➤ Workforce support of staff
- ➤ Governance, Leadership & Management

Guidance to the assessment and judgment framework (GAJF) - assist and support service providers

Core Set of Standards

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

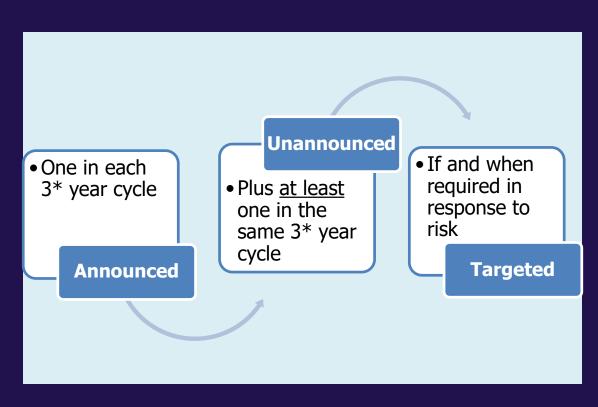
Standard 5.8 – Providers have systematic monitoring arrangements to identify opportunities to continually improve

Workforce

Standard 6.4 – Providers support their workforce in delivering high quality, safe and reliable healthcare

The Inspection Cycle

Type & Frequency of inspection



Minimum of 2 inspections in each 3 year cycle

Announced

* Unannounced Inspection plus where required

Targeted inspection in response to regulatory risk; If HIQA becomes aware of specific risk within a service, a targeted inspection may be carried out in response.

* may have more than one if required

"Floor to Board Approach" HIQA's new monitoring programme

Assurance 5.2,
5.5, 5.8, 6.4

Ensuring 2.8,
3.3

Patient Experience 1.6,
1.7, 1.8, 2.7, 3.1

Board

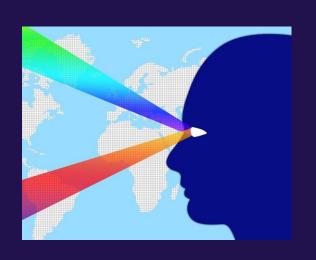
Middle Managers and
Clinical Leaders

Floor – clinical area

- Pro-active Monitoring
- Targeted Governance Review (Section 8)
- Section 9 Statutory Investigation

How will HIQA assess compliance?

Observation, Communication and Documentation





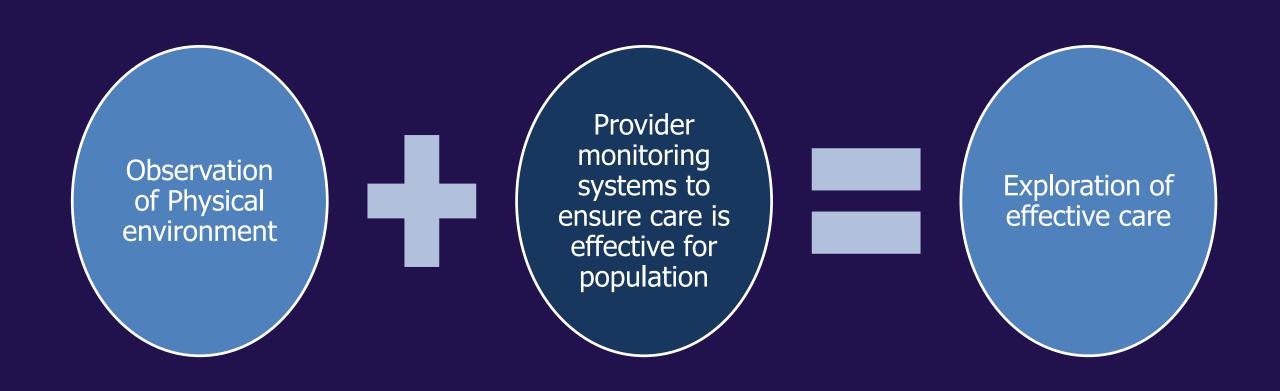




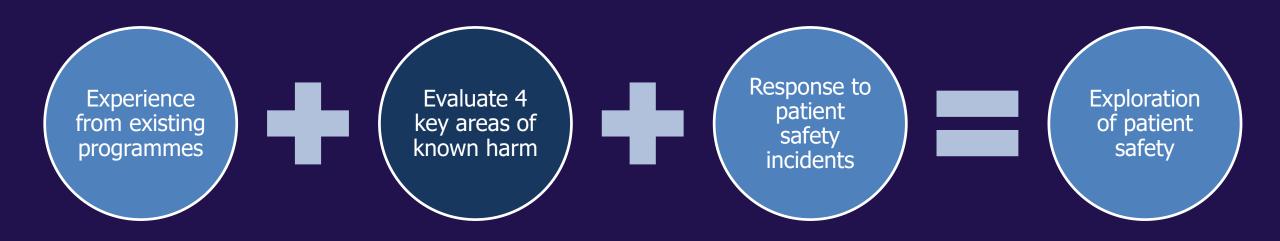
Do patients /service users experience person centred care?



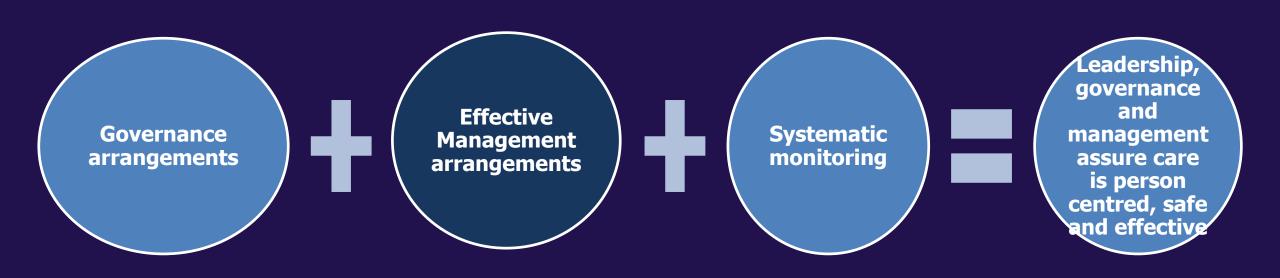
Do patients /service users experience effective care in a suitable environment?



Do patients/service users experience safe care?



Is the service well run and well managed in the interests of patients / service users?



Do patients/ service users experience person centred, safe and effective care from the workforce?



Assessment Judgment Framework (AJF)

Purpose

- Supports service providers & HIQA inspectors
 - ✓ gathering evidence when monitoring
 - ✓ assessing a service
 - ✓ making judgments on compliance.
- Sets out examples of the lines of enquiry to be explored (questions to be asked) by inspectors.
- Outlines the judgment compliance levels, which we term 'compliance descriptors'

Guide to Assessment Judgment Framework published 6 April 2022



Assessment of Standard 3.1 (Safe Care) in respect of the Deteriorating Patient

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

"Systems in place to identify and reduce the risk of harm associated with a delay in recognising and responding to people using the service whose condition acutely deteriorates. Policies, procedures and guidelines are developed and implemented for early detection and emergency response for patients whose condition is deteriorating". (Guide to Assessment Judgment Framework HIQA 2022)

- Implementation of the Deteriorating Patient Improvement Programme at hospital level
- Early Warning Systems in place in acute services
- Use of approved charts (INEWS, PEWS, IMEWS and EMEWS) for the various cohorts of patient irrespective of location
- Identification of Sepsis
- Training
- Audit
- Learning

How this new monitoring programme approach achieves our aim

- Aims to evaluate that care is person centred, safe and effective -Primary focus is on the patient, starts with the patient and what supports them and ensures their safety
- Will work across the spectrum of services
- Applicable across all potential services we may monitor in the future

- Safe care **NS 3.1** incorporates previous thematics and maintains effort in these areas with focus on known areas of potential harm
- NS 6.4 Focus on support of workforce in particular post pandemic but relevant at all times
- Inclusion of NS 2.8 and 5.8
 evaluates capability in system's
 own monitoring

Next Steps

- Commenced routine and risk based Monitoring Programme -Qtr 1, 2022
- Publish inspection reports of compliance in inspected services
 - Give a view to the public of our assessment
 - Provide learning for services on our expectation

Current status of management of the deteriorating patient

- From the limited inspections carried out thus far in this new approach, we can tentatively acknowledge that the oversight and management of the deteriorating patient is developing in acute and community services
- With our inspection approach and the work of the DPIP, we believe that the two pronged approach through monitoring and QI will embed this further in all healthcare settings.

Any questions?

Thank You.



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