An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Chliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

2022

HSE Patient Safety Supplements: Guidance Document

Patient Safety Together:
learning, sharing and improving

QPSIM-PST 006

Contents

Version Control

Doc Control	Date	Version	Created by	Reviewed By	Approved By
QPSIM-PST-006	November 2022	Version 1	PST Learning Team	Assistant National Director, QPSIM	Assistant National Director, QPSIM

1. What are HSE Patient Safety Supplements?

HSE Patient Safety Supplements (PSS) inform HSE and HSE funded agencies of timely and relevant quality and patient safety information for learning purposes. An example of a HSE PSS is included in Appendix 1.

2. Where can I find HSE Patient Safety Supplements?

HSE PSS are freely accessible through the HSE Patient Safety Together website at https://healthservice.hse.ie/organisation/nqpsd/pst/

3. What content will be included in a HSE Patient Safety Supplement?

The content of a PSS may be based on several sources of patient safety information including;

- New national quality and patient safety initiatives
- Analysis of patient safety incident reporting,
- Analysis of patient safety incident reviews
- Reports from front line services
- New national or international research
- New information on an aspect of patient safety from colleagues and experts from within the HSE and from other jurisdictions
- Suggestions received at patientsafetytogether@hse.ie
  The lay out options for a PSS is outlined in Appendix 2.

4. How can I use HSE Patient Safety Supplements to inform learning?

There are many ways in which PSS can be used to inform learning locally

- Review / Audit your service to determine how/if the PSS applies to you
- Download and print the PSS and display for staff
- Discuss the PSS with colleagues at;
  - Safety/Risk Huddles
  - Ward Rounds
  - Quality & Safety Meetings and Committees
  - Department Meetings
- Encourage Student Co-ordinators to share and discuss the PSS with all student groups within your local service
- Discuss the PSS with your Service User / Resident / Patient Representative Groups
- Include the PSS in your local newsletter and detail how it impacts your local service
- Share in your local social media i.e. Twitter, Instagram.

5. Can I contribute to a HSE Patient Safety Supplement?

If you are interested in contributing to the development of a PSS, please contact the Patient Safety Together Learning Team at patientsafetytogether@hse.ie Please note that the PSS will be written in collaboration with the National Quality and Patient Safety Directorate (NQPSD) Patient Safety Together Learning Team +/- other relevant stakeholders including patient partners.

If you are considering co-developing a PSS, please consider the following:

1. It is important that a subject with clear learning to share is identified. The PSS will be developed to ensure the reader can identify any learning or recommendations easily by making sure the content and style of the message is consistent, honest and transparent.
2. The message must be clear and focused and has been tailored to suit the audience.
3. The PSS should include the Patient or Service User story when possible, through use of individual stories or case examples. Please note if an individual patient story or case is being used the story should be anonymised unless you have obtained explicit consent from the patient/service user or relevant person to include their identifiable details. Similarly, details relating to a service or staff must be anonymised also.
4. The content should be structured to fit the headings in the template, however there is flexibility in each layout as not all sections might apply to your PSS.
5. The PSS should be kept to five pages maximum.
6. The PSS must be written in 'Plain English'
    - Plain English is a way to write and present information so a reader can understand and act on it after a single reading. It means writing accurately and clearly for the intended reader, using every day words, and avoiding jargon, abbreviations and acronyms, except for people who will understand it. (Click for more communicating clearly resources)
7. If the PSS is being co-developed from a local service e.g. Acute Hospital Division or Community Healthcare Organisation then sign off from the appropriate accountable person will be needed such as the Chief Executive Officer/ Chief Officer, Head of Quality and Patient Safety (or designate)

6. How are HSE Patient Safety Supplements approved?

For PSS developed with Acute Hospital Groups or Community Healthcare Organisations approval of AHG/CHO QPS committee or equivalent is required prior to collaboration with the PST Learning Team.

All PSS will be reviewed and approved by the HSE National Patient Safety Alert Committee. Approval to publish on Patient Safety Together will be via the HSE NPSA Committee.

7. How can I connect with the Patient Safety Together Learning Team?

The Patient Safety Together Learning Team is a part of the Incident Management Team of the National Quality and Patient Safety Directorate. You can connect with the PST Learning Team by email at patientsafetytogether@hse.ie

For more information, see our website: https://healthservice.hse.ie/organisation/ngpsd/pst/

Appendix 1: Sample Patient Safety Supplement

Patient Safety Together:
learning, sharing and improving

PATIENT SAFETY SUPPLEMENT

Date published: December 2022

Open Disclosure conversations with vulnerable persons

This Patient Safety Supplement focuses and shares learning on open disclosure conversations following a patient safety incident involving a vulnerable person.

The purpose of this Patient Safety Supplement is to demonstrate that a person who is vulnerable, for whatever reason, is entitled to open disclosure on an equal basis with others. Learning can be shared with colleagues and other services to promote the rights and safety of the person involved.

Ann's Story

Ann is an 18-year old person who has an autism spectrum disorder and complex communication needs and attends a day service with four other people. Ann was pushed by another service user and fell which resulted in a cut to her leg and elbow.

After ensuring that Ann's injuries had been attended to the Clinical Nurse Manager (CNM) set up an open disclosure meeting with Ann and her support worker, who she has a good relationship with. The CNM acknowledged Ann's fall to her, said sorry that it happened and for the obvious upset that it had caused.

The open disclosure meeting took place in an environment where Ann felt most relaxed. A total communication approach was used to optimise Ann's understanding of what was being said in the meeting. The team refreshed their Lámh sign language, including the word for "sorry" and used pictures to guide Ann through the meeting. The team also used an easy read agenda to help with the meeting. The team encouraged Ann and her support worker to bring an item of comfort for Ann. It was also pre-arranged that Ann would do something after the meeting that she really liked and in this case Ann went to the park with her support worker. This ensured that Ann had a clear indication that the meeting was finished. With Ann's consent her father was also informed about what happened and an apology was provided to him.

Following on from the incident and open disclosure meeting a review of the service was completed and a safeguarding investigation was completed.

Expert Comment and Recommendations

Open Disclosure must occur following all patient safety incidents, in particular when there was harm, in compliance with the HSE Open Disclosure Policy (2019). As outlined in Ann's story, staff must work on the presumption that every adult has the capacity to make decisions about their care. ***A person whose decision-making capacity is in question is entitled to open disclosure on an equal basis with others and should be provided with all the necessary supports to facilitate their involvement in the process.*** Open disclosure to the relevant person must be undertaken with the consent of the person involved.

Ms. Angela Tysall

National Lead for Open Disclosure

NATIONAL OPEN DISCLOSURE PROGRAMME

A rights based, supportive approach to open disclosure is required ensuring that those involved are involved in the process from the outset and that the focus is on;

- the specific circumstances relating to the patient safety incident
- the person involved
- the specific needs of that person

The support of an independent advocate must also be considered and facilitated as appropriate.

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Documentation of Open Disclosure

Details of the open disclosure discussion held, including an account of the apology provided, must be recorded in the healthcare record. A record of the formal open disclosure meeting must also be provided to the person and / or their relevant person, as appropriate. If the conversation is not documented, then there is no evidence that it has taken place.

The open disclosure fields on the National Incident Management System (NIMS) must also be completed as part of the incident record. The required recording of open disclosure conversations on NIMS continues to improve since the launch of the updated HSE Open Disclosure Policy in 2019.

The National Advocacy Service

The National Advocacy Service (NAS) provides an independent, confidential and free issue based advocacy service that puts the person at the center and adheres to the highest professional standards. NAS recognises that people have a right to be told when something goes wrong with their care or treatment in line with the National HSE Open Disclosure Policy (2019). NAS has a particular remit to work with people with disabilities who are in vulnerable situations, such as people who are isolated from their community of choice or mainstream society, may communicate differently and who have limited formal or natural supports.

For further information on the supports available from NAS please see their website https://advocacy.ie/ , email info@advocacy.ie or Tel 0818 07 3000.

Patient Safety Strategies and Resources supporting Open Disclosure

- HSE Patient Safety Strategy (2019-2024) available here
- HSE Open Disclosure Policy (2019) available here
- St Michael's House Easy Read Open Disclosure Policy available here
- HSE Incident Management Framework (2020) available here
- Open Disclosure National Training Programme —link to access training here
- HSE Staff Support Programme and link to webpage here
- Assisted Decision Making (Capacity) Act (2015) information available here
- National Advocacy Services—information available here

Future Focus

- The Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 will provide legislative provisions for mandatory open disclosure within the HSE and its funded services. The enactment of this Bill is expected in 2023.
- The National Open Disclosure Policy Framework, which is expected to be published in 2023, will inform the direction of national policy on open disclosure across all public and private health and social care services.

Developed by

- National Open Disclosure Office, Quality and Patient Safety Incident Management
- National Advocacy Service
- NQPSD Patient Safety Together Team

For more information please contact patientsafetytogether@hse.ie

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Appendix 2: Layout of a Patient Safety Supplement

The following includes options of headings to include in the PSS, however depending on the content not all sections will be used for every PSS.

1. Title of PSS

Outlines where the learning has been sourced from and the purpose of the PSS. To maximise learning it is recommended the scope of the PSS is quite focused.

2a. Case example

Short summary of incident or situation. Identify your key message and desired outcome. Check if your message is expressed simply and in language that can be understood with ease? Think about the reader.

or

2b. Patient Story

Brief description of the event/incident focussing on the patient or service user. If possible work with the patient, service user or their family to use their own words and account of the events.

3. Expert comment

Identify and collaborate with experts / specialists in the speciality – e.g. Clinical programmes, Patient/Service User, National Leads etc. Include key considerations and evidence- informed recommendations.

4. International Evidence and best practice

Search for and include any international evidence and best practice guidelines that can support the PSS?

5. Recommendations

Identify and include any key Policies, Guidelines and Protocols etc. available to support your content and help the readers to widen their learning and access more information easily.

6. Developed by

Acknowledge who developed the PSS and any collaborators that might have contributed.

7. References

Include a brief list of any sources to allow the reader to identify and access the sources referenced

The Patient Safety Together Learning Team can help you edit the template once the content has been anonymised and approved.