

## Minutes of HSE National Patient Safety Alerts Committee (NPSAs) Patient Safety Together: learning, sharing and improving

**Meeting No.** Eighteen

**Date:** 26<sup>th</sup> April – MS Teams 10:00 -11:30

<b>Present</b>		
Dr Darren McLoughlin, (DMcL) - ED Consultant – Committee Chair	Lorraine Schwanberg (LS) – AND QPS IM - Committee Co-Chair	Catherine Hogan (CH) – QPSIM & Patient Safety Together (PST) Project Lead
Noemi Palacios (NP) – QPSIM & PST Co-ordinator	Siobhan Lynch (SL) – Quality and Patient Safety Manager – CHO6	Alan O’Gorman (AOG), Director of Nursing, UL Hospitals Group
Judith Martin (JM) - Medical Device and IVD Advisor – Medical Devices, HPRA	Joseph McNeela (JMcN)- Pharmacovigilance, HPRA	Ciaran Browne (CB) - HSE Estates Lead, HSE Acute Operations
Fiona Garvey (FG) - National QPS – Community	Tibbs Pereira (TP) - Patients for Patient Safety Ireland	Marie Ward (MW) - Human Factors Lead, St James Hospital
Darren Scully (DS) – Pharmacovigilance Risk Communication and Assessment Manager (HPRA)	Sinéad Brennan (SB) - QPS Acutes Lead, IEHG	Mairead Twohig (MT) - Risk & Incident Lead, Acute Operations
Julia Louw (JL), Post-doctorate Researcher		
<b>Apologies</b>		
Edel O’Toole (EOT) - Health & Social Care Professional Lead	Patricia O’Dwyer (POD) - Patient Partner Representative – SAGE Advocacy	Gethin White (GW) – Librarian, Knowledge User Lead, HSE Library
Patrick Murphy (PM) - Assessment and Surveillance Manager – Medical Devices, HPRA		

	<b>Items</b>	<b>Actions</b>
<b>1.</b>	<b>Welcome &amp; Apologies (Committee Chair)</b> <ul style="list-style-type: none"> <li>• The Chair welcomed members to the meeting and conveyed apologies</li> <li>• Quorum reached</li> </ul>	
<b>2.</b>	<b>Review of Minutes (Committee Co-Chair)</b> <ul style="list-style-type: none"> <li>• Minutes and associated actions of 22<sup>nd</sup> March 2024 were reviewed, updated and signed off</li> <li>• MT to follow up with PST regarding potential PSS (air embolism)</li> </ul>	<b>MT</b>
<b>3.</b>	<b>HSE NPSAs/PSS Updates</b> <ul style="list-style-type: none"> <li>• CH gave an update regarding: <ul style="list-style-type: none"> <li>○ Two Draft PSS in development: Risk of extravasation injury from high risk antibiotics and Medical device related pressure ulcers. A discussion took place regarding the risk/criteria considered when selecting topics for developing supplements. Actions to note: <ul style="list-style-type: none"> <li>- CB will share Medical Devices Risk Assessment and decision making with PST</li> <li>- PST will re-circulate Standard Operational Procedures (SOP)</li> <li>- LS will engage again with the HSE Clinical Design and Innovation team re showcase patient safety learning opportunities via Patient Safety Together</li> <li>- MT will share with PST Analysis of Prone Position Pressure Injuries reported on NIMS &amp; Associated Guidance Information developed after Covid-19</li> </ul> </li> <li>○ Patient Safety Together – One year evaluation survey results. Brief presentation and discussion took place. To note: <ul style="list-style-type: none"> <li>- Data for close out of NPSAs on QPS eAlert system by service rather than by individual to be conducted</li> <li>- positive feedback received and good engagement with resources</li> </ul> </li> </ul> </li> </ul>	<b>CB PST LS  MT</b>

	<ul style="list-style-type: none"> <li>- Ongoing work to improve promotion of patient safety learning and communications/marketing piece will continue</li> <li>- QPS eAlert System will require changes to reflect new Regional Executive Offices structure – initial conversations and updates with support team have started</li> </ul> <ul style="list-style-type: none"> <li>• LS updated the committee on a number of meetings relating to potential patient safety risks from medical devices HSE Medical Devices and HPRA are following up with manufacturers. No further actions required at this time.</li> </ul>	
<b>4.</b>	<p><b>Review of intelligence submitted</b></p> <p>Current QPS issues and learning reviewed. Brief conversation took place regarding additional sources for sharing learning.</p> <p>Actions:</p> <ul style="list-style-type: none"> <li>○ LS to follow up with MT regarding some NIMS incident data</li> <li>○ LS to follow up re Transfusion-associated circulatory overload (TACO) in Ireland</li> <li>○ JMcN to check if any reports are available re PAXLOVID® ▼ (nirmatrelvir; ritonavir)</li> </ul>	<p><b>LS</b></p> <p><b>LS</b></p> <p><b>JMcN</b></p>
<b>5.</b>	<p><b>Date of next meeting</b></p> <p>Meeting ended at 11:23 am.</p> <p>Next meeting will take place on Friday, May 24<sup>th</sup> 2024 at 10:00-11:30. PST to send updated calendar invite</p>	<b>PST</b>

<b>Action Summary</b>			
	<b>Action</b>	<b>Assigned to</b>	<b>Due</b>
i	MT to follow up with PST regarding potential PSS (air embolism)	MT	Before next meeting
ii	CB will share Medical Devices Risk Assessment and decision making with PST	CB	Before next meeting
iii	PST will re-circulate Standard Operational Procedures (SOP)	PST	Before next meeting
iv	LS will engage again with the HSE Clinical Design and Innovation team re showcase patient safety learning opportunities via Patient Safety Together	LS	Before next meeting
v	MT will share Analysis of Prone Position Pressure Injuries reported on NIMS & Associated Guidance Information developed after Covid-19	MT	Before next meeting
vi	LS to follow up with MT regarding some NIMS incident data	LS	Before next meeting
vii	LS to follow up re Transfusion-associated circulatory overload (TACO)in Ireland	LS	Before next meeting
viii	JMcN to check if any reports are available re PAXLOVID® ▼ (nirmatrelvir; ritonavi	JMcN	Before next meeting
ix	PST to send updated calendar invite	PST	After meeting

For revision:

Review the process regarding naming affected sites with a view to a standardised approach	Committee	June/July 24
---	-----------	--------------