An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

Edition 04 | March 2024

Quality and Patient Safety MATTERS

#AllThingsQuality

New sepsis campaign

Patient Safety Act latest updates

Collaboration sees discovery of a new species of bacteria

CHECK OUT THE LATEST IN QUALITY AND PATIENT SAFETY EDUCATION ALL IN ONE PLACE! 2024 PROSPECTUS

A publication from the HSE National Quality and Patient Safety Directorate

A message from the editorial team

Welcome!

In this our fourth edition of Quality and Patient Safety Matters #AllThingsQuality, it is a pleasure to share the latest quality and patient safety news, stories from teams around the country, educational content and upcoming training, events and networking opportunities.

Thanks to all of our contributors who work each day to improve the experience and care of people who use health services. We hope that as you read their stories, you might find insight and inspiration.

Read about National Clinical Guidelines for People with Dementia, health literacy, a new species of bacteria and Spark Innovation. We also share the latest updates on the Patient Safety Act, National Centre for Clinical Audit and the Patient Safety Together alerts on adult and paediatric sepsis.

We also have an article on sepsis and we hope that as a healthcare professional or in your role as a carer, parent or patient that the information may be helpful. One in five people who get sepsis dies - the figures are stark and yet when members of the public were asked, almost half (44%) said they did not know the signs or symptoms.

If you are leading a team, or working closely with colleagues click on the link for the 'Civility Saves Lives' QPS TalkTime. This episode provides invaluable guidance for those experiencing incivility in the workplace. You can also access our latest Walk and Talk Improvement Podcasts or the 2024 Prospectus of Quality and Patient Safety Education which has something for everyone interested in QPS.

As always, please do contact us if you have any feedback on how we can continue to improve the newsletter. We also look forward to hearing your stories for our next edition. You can share your ideas for inclusion by clicking here.

Happy reading!

Juanita Guidera
Editor

Sheema Lughmani
Deputy Editor

The newsletter is an interactive PDF. When you click on a hyperlink, it will bring you directly to the website, webinar, registration link, podcast or other resource mentioned (where links are available). To access, just hover and click on the text. This is the symbol you will see beside a hyperlink:

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If you would like to share your ideas for content in Quality and Patient Safety Matters, Edition 05 please complete the online survey.

Welcome to our fourth edition of the Quality and Patient Safety Matters #AllThingsQuality newsletter

Dear colleagues,

Thank you for reading our fourth edition of Quality and Patient Safety Matters. While recent announcements of the structural changes within the HSE bring a sense of progress, we also know that there is much yet to be finalised. In our work with services, many staff have spoken about the challenges of working in uncertaintly, where the governance and our ways of working are changing as we explore how best to provide integrated care.

This cycle of change is not new in healthcare and many of us will have had this experience before. The one certainty is that the people using our services still need a quality and safe service. As we navigate the transitions of structures and processes, our attention on providing safe services has never been more important for our family, neighbours and friends in our community.

In this edition of Quality and Patient Safety Matters, you will read about quality and patient safety developments from staff, patient partners and the National Quality and Patient Safety Directorate Team. We also share essential patient safety alerts on sepsis and updates on the Patient Safety Act and clinical audit.

We also share resources that we hope will help you in this period of change, including our most recent Walk and Talk Improvement Podcast from Professor Helen Bevan on ‘Embracing the Unknown’. This episode is a resource for anyone navigating change or improvement work. Our Prospectus of Quality and Patient Safety Education has just been launched and provides opportunitites to continue your professional development through a broad range of programmes.

As always we have more content that we can share in a short newsletter but we hope that what you read captures the essence of the healthcare staff in our system who continue to aspire to provide dynamic, timely and safe care.

Thank you to all who contributed to this publication and to you our readers for taking the time to read it. We hope it will assist you in your work.

Best wishes,

Dr. Orla Healy,
National Clinical Director, Quality and Patient Safety,
National Quality and Patient Safety Directorate.

Subscribe to our newsletter to stay up-to-date on all things quality and patient safety.

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What is the National Quality and Patient Safety Directorate?

The National Quality and Patient Safety Directorate is a team of individuals working across Ireland in partnership with regions, patient partners and other internal and external partners to improve patient safety and the quality of care. Our work is guided by the Patient Safety Strategy 2019-2024.

Our vision for patient safety is that all patients using health and social care services will consistently receive the safest care possible by:

- Building quality and patient safety capacity and capability in practice
- Using data to inform improvements
- Working with people to identify, understand and share safety learning, advocate for open disclosure and develop the national incident management system
- Providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Learn more about our work and our team www.hse.ie/nqpsd

Patient stories: Gemma's Journey

Patient representative on the Trauma Steering Group Committee, Gemma Willis shares her story in her own words.

> **"Those 16 hours were so crucial. I might not have lost my legs. I might not have lost my toes."**

My name is Gemma Willis. I am patient representative on the Trauma Steering Group Committee and this is my trauma story.

In August of 2015 I was involved in a bad road traffic accident and I was brought to hospital. They stabilised me and assessed where was the best hospital for my needs. It took 16 hours before I got brought to the Mater Hospital. Those 16 hours were so crucial. In those 16 hours I might not have lost my leg. I might not have lost my toes.

It shows how important it is to be brought to a hospital that is able to look after trauma and deal with trauma. When I was being transferred, my father was told that I mightn't even make the journey to the Mater.

When I arrived to the Mater they put me in an induced coma and started operating straight away. I had multiple operations with multiple injuries. Listing my injuries from head to toe, I have a shunt going from my brain to my heart, the seatbelt pressed my bowel and burst one of the arteries going down my leg. I broke my spinal cord and I have a rod stabilising my spinal cord. I am an amputee on my right leg above the knee. I lost my toes on my left leg and I broke a bone on my cheek which they had to stabilise. I've had 11 operations in the Mater over a period of nine months.

While I was in the Mater, waiting to be brought to the National Rehabilitation Hospital (NRH), I was told they they were going to send me back to the first hospital. Typically you are meant to go back to the hospital that you started from. However, I point blank refused this.

I had been moved around so much. I had so much going on in accepting my injuries, accepting my new life that I didn't want all of this change. Moving would have made this impossible. It felt being asked to start all over again with all new doctors who didn't know everything that is required of my care. So I stayed in the Mater.

After nine months, I was transferred over to the brain injury section of the NRH. I did three months on the brain injury ward before I eventually was transferred to the spinal ward, where I worked hard for four months. Finally after 16 months and 14 operations, I came home.

Becoming a patient representative

When I started my new life as patient representative, I started to see how important trauma care services are and how improvements to trauma care for patients like myself could completely transform our care.

For example, if this was set up in 2015, I'd have been brought straight to the Mater. There would have been one doctor overseeing all my medical needs, instead of seven doctors that I did have. They would have a bed ready and waiting for me, with doctors on hand for the surgeries I was getting.

Crucially, there would be one coordinator to help instruct myself and my family on my new life. They would inform us about changes, different procedures and operations that I might have had to be having, and centralise all of the rapid information that you're getting.

This goes beyond your stay at the hospital as well. You need to be able to have this link even once you're home. For example, I developed a pressure sore and we didn't know where to go or what to do or who to contact. I was brought to a hospital that was able to manage the pressure sore but didn't know how to treat me and all my different and complex medical needs. I felt I didn't get the care that I deserved and needed with all my injuries.

Another key aspect is assessing rehab needs at an earlier stage. This would mean that you get to somewhere like the NRH sooner, instead of the nine months that I waited. Earlier assessment and access to rehab means you can be brought home sooner.

Furthermore, another improvement with this trauma system is the ambulance, which would now bring you to one of the major trauma centers or a hospital that is able to deal with trauma.

I am really proud to be patient representative on the Trauma Care Steering Committee and be able to improve trauma care services for patients like me. It's great comfort to know that they will be looked after, that they will be brought to the necessary hospital that can care for their needs.

Where can you learn more and what can you do?

- Watch Gemma's story on our YouTube channel
- Hear from Gemma and the Trauma Steering team in episode 4 of the Walk and Talk Improvement podcast:
  "Using data to improve" Featuring:
  - Gemma Willis, Keith Synnott, Damian McGovern, Professor Deirdre Madden
- Consider how you can involve patients in service design.

John's Campaign launched at Letterkenny University Hospital

In conversation with Martina Porter, Quality and Patient Safety Manager, Letterkenny University Hospital

LETTERKENNY UNIVERSITY HOSPITAL

John's Campaign was founded after the death of Dr. John Gerrard in November 2014. It was focused on the right of people with dementia to be supported by their carers in hospital. It is being adapted in Letterkenny University Hospital for all patients who may benefit from this approach.

What is John's Campaign?

Letterkenny University Hospital has introduced John's Campaign. This is a movement to help staff recognise the importance of working with family carers in the support and care of people with additional needs who find themselves in hospital. The movement brings benefits to both patients and staff.

How does John's Campaign help patients and carers?

John's Campaign is enveloped in patient and family-centred models of care.

The campaign helps us advocate for people in our community who find it hard to cope in stressful and unfamiliar environments. Hospital stays can be a time of anxiousness, loneliness and upset. When we welcome family carers onto the wards outside of visiting times according to the needs of the person, patients may feel calmer and less disorientated. This can help with communication and participation in medical treatment.

Welcoming carers, whenever needed, also provides recognition that they may be experts in their loved one's care needs. It recognises patient carers as partners in care, who may be well versed in their loved one's medical history and with the potential to assist with medical decision-making and discharge planning where appropriate. A hospital admission may be the first time a carer is recognised or recognises themselves as such. Hospitals are well placed to identify family carers and offer support and advice to the carer to look after their own wellbeing also.

Why did Letterkenny University Hospital get involved?

We hope that by adopting this campaign, it is a tangible demonstration that our hospital wants to provide the best possible patient experience for people with additional needs, their carers and staff. When family carers are involved from admission to discharge the result is better quality of care, improved outcomes and improved patient experience for the patient.

How have we implemented John's Campaign?

We have shaped our visiting policy to advocate for people who often do not have the power to lend their voices to the debate and dialogue around hospital visitation rights. Implementing John's campaign does not have to be difficult. Small changes can make a big difference to patient experience and staff satisfaction, and improve patient outcomes.

- Martina Porter, Quality and Patient Safety Manager; Niamh O'Donnell, End of Life care Co-Ordinator

- Aoibhinn Moreton, Quality and Patient Safety Team; Niamh O'Donnell, End of Life care Co-Ordinator; Martina Porter, Quality and Patient Safety Manager

Where can you learn more?

Read our piece in Health Service News to learn more about John's Campaign.

CONTACT US

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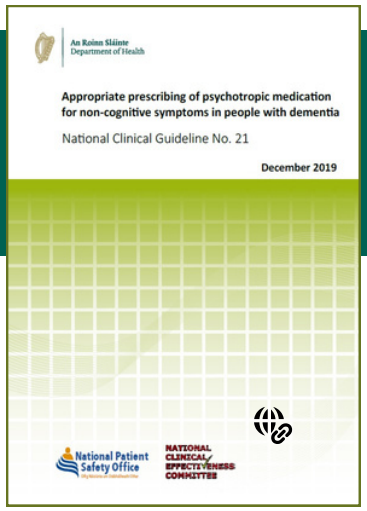
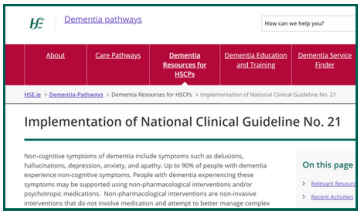
National Clinical Guideline No. 21

Implementing a National Clinical Guideline on the "Appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia"





What are psychotropic medications?

Psychotropic medications are medications which affect the mind, emotions, mood and behaviour. There are a number of types of psychotropic medications including antipsychotic medications and benzodiazepines. Some psychotropic medications may be beneficial for both cognitive and non-cognitive symptoms of dementia. Cognitive symptoms of dementia include memory loss, problems with language, and difficulty managing everyday tasks. All medications can cause side effects. These vary between the different types of psychotropic medications, and also vary from person to person.

This guideline was published first in December 2019. It provides essential information on a national patient safety topic that impacts many of the people using our health services.

Side effects might include:

- Drowsiness and confusion
- Poor balance and falls
- Weight gain and diabetes
- Constipation
- Shaking or tremors
- Increased risk of pneumonia
- Increased risk of stroke and dying (this side effect is specifically linked to antipsychotic medications)

What are non-cognitive symptoms of dementia?

Non-cognitive symptoms are symptoms related to mood, behaviour and psychosis.

Non-cognitive symptoms may include:

- Mood disturbances
- Personality changes
- Agitation
- Aggression
- Pacing
- Altered sexual behaviours
- Changed sleep patterns
- Appetite disturbances
- Hallucinations
- Delusions (false beliefs)

Up to 90% of people with dementia display non-cognitive symptoms. These can present as mild, moderate or severe. People with dementia experiencing these symptoms may be supported using non-pharmacological interventions and / or psychotropic medications.

Non-pharmacological interventions are non-invasive interventions that do not involve medication and attempt to better manage complex needs. Some examples of non-pharmacological interventions include music therapy, physical exercise and cognitive stimulation therapy.

What is National Clinical Guideline No. 21?

National Clinical Guideline No. 21 (NCG No. 21) (Appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia) was published in December 2019 by the Department of Health. It aims to guide the appropriate use of psychotropic medication for non-cognitive symptoms being experienced by people living with dementia.

Who will use the guideline?

This guideline is relevant to all doctors, nurses, pharmacists and health and social care professionals in Ireland who provide care to people with dementia.

Where does the guideline apply?

The guideline applies to all settings that provide care for people living with dementia.

A sister document: "Non-cognitive symptoms of dementia: Guidance on non-pharmacological interventions for healthcare and social care practitioners" was published in 2019 by the HSE. This document provides detailed information and guidance on the use of non-pharmacological interventions for non-cognitive symptoms of dementia.

How is NCG No. 21 being implemented?

An Implementation Programme for NCG No. 21 commenced in 2022 and is ongoing.

Key objectives of the implementation programme

- Raise awareness of the risks of psychotropic medications for people with dementia, and raise awareness of NCG No. 21 as a key resource to guide clinical decision-making.
- Develop a multi-component education programme to include facilitator education and an eLearning programme of education.
- Provide education to relevant staff on the content of NCG No. 21.
- Develop an audit tool and manual to assess compliance with NCG No. 21, and provide training on use of this audit tool.
- Undertake a comprehensive evaluation of the implementation of NCG no. 21 to assess the reach of the education and training programme.

How can I get involved in the implementation of this clinical guideline?

There are a number of things you can do to get involved.

- Complete the HSeLanD module "Support pathways for people with non-cognitive symptoms of dementia". This 30-minute module will help you to determine the best person-centred supports for a person with non-cognitive symptoms of dementia. It will also help you to recognise the risks of unnecessarily prescribing a psychotropic medication.
- Attend a one-day education programme and become a Local Facilitator for the Implementation of NCG No. 21. The Facilitator Education Programme is being rolled out nationally.
- Contribute to an audit of psychotropic prescribing in your setting.
- Attend one or more locally delivered education sessions (see sessions on the right).

Locally delivered education sessions

Delivering person-centred care for non-cognitive symptoms of dementia

This education session seeks to support participants to:

- Explain the steps you must take to determine the best supports for a person with non-cognitive symptoms of dementia.
- Describe how you can deliver a person-centred approach to dementia care using non-pharmacological interventions.
- Summarise the types of non-cognitive symptoms of dementia.
- Outline the risks you associate with psychotropic prescribing and administration.

Prescriber education: Implementation of NCG No. 21

This education session supports prescribers of psychotropic medications for non-cognitive symptoms of dementia to:

- Describe the different types of psychotropic medications and their use for non-cognitive symptoms.
- Report the potential risks of psychotropic prescribing.
- Identify the key recommendations of NCG no. 21 and the good practice points outlined.
- Implement the practice changes required as a result of the recommendations.

Using quality improvement methodology to support the implementation of NCG No. 21

This education session is targeted at staff who will perform an audit of psychotropic prescribing within their setting, with the following learning outcomes:

- Describe the core components of the audit tool and the information required to complete this.
- Audit patient charts / healthcare records using the audit tools.
- Understand how improvement can be driven by the application of quality improvement frameworks.

Where can you access more information?

Contact the Project Lead for the Implementation Programme
Dr. Mairéad Bracken-Scally:
mairead.brackenscally@hse.ie

Visit the Implementation Programme webpage

Working towards a literacy friendly health service at UL Hospitals Group

Insights from Niamh Quinn, Programmes and Campaigns Manager, UL Hospitals Group

“A health literate organisation makes it easier for people to navigate, understand and use information and services to take care of their health.”

The UL Hospitals Group Health Literacy Committee has sought to embed health literacy and plain English into the culture of UL Hospitals Group. Set up in 2017, during its work, the Committee identified a clear need for a service to support staff in delivering literacy-friendly materials to patients.

The National Adult Literacy Agency (NALA) has identified a set of standards for becoming a literacy-friendly hospital. In line with NALA’s five step guide to becoming a literacy-friendly hospital, the Committee set about carrying out a ward based health literacy audit in 2017. The audit identified the need to create a guideline for staff with a clear process and resources to help them. The Health Literacy Committee has had limited time to develop such a dedicated service and the plan is now to look at how UL Hospitals can do this.

Our vision

Our vision is:

- to become the first public hospital group in Ireland to appoint a Health Literacy Officer to develop internal processes and standards to use plain English in our written patient information *(Communications and Health Literacy officer appointed in June 2023)*
- to support the delivery of a literacy-friendly health service and work towards achieving the National Adult Literacy Agency’s (NALA) literacy-friendly standards.

What is the impact of poor communication?

Inconsistent messages and letters / patient information leaflets, with little oversight in terms of language or style, can impact on patients’ understanding of what we are communicating and also, the overall patient experience.

We have seen this impact specifically in the results of the National Inpatient Experience Survey each year, in particular with regard to communication of standardised discharge and patient information.

Guideline and toolkit

In 2019, the Health Literacy Committee launched a ‘Guideline to assist staff in using plain English’ with accompanying resources and toolkit and a clear process.

The resources toolkit includes:

- The UL Hospitals Style Guide
- The HSE Communicating Clearly Guide
- Layout guides for letters and leaflets
- Sample letters and leaflets
- Leaflet templates

The Committee also provided ongoing support through monthly health literacy clinics (pre-COVID-19) to promote the use of the Guideline and to assist staff in using the resources.

Where can I find out more information / get involved?

To find out more you can Niamh Quinn: *niamh.quinn3@hse.ie* or Catriona Kiely, *catriona.kiely@hse.ie*. You can also talk to your own Communications Team to find out what is happening in your service and how you can get involved.

Why is health literacy important?

Health literacy and numeracy is important for everyone. NALA research shows us that:

- 1 in 5 Irish people are not fully confident that they understand the information they receive from their healthcare professional.
- 66% of people have difficulty understanding signs and directions in Irish hospitals.
- 43% of people would only sometimes ask their healthcare professional to clarify the information if they did not understand something.
- 17% of people have taken the wrong dose of medication at least once.

International research has also shown that people who are better informed about their health have more effective consultations with their healthcare provider and are more likely to take their medication correctly. This results in improved health outcomes and living longer.

The most recently conducted population health literacy surveys (HLS19) shows that:

- About 50% of the adults in Europe did not have adequate health literacy levels.
- Health Literacy is associated with a social gradient: higher levels of health literacy mean better health outcomes.
- Significant potential effects of Health Literacy on health-relevant indicators (such as the higher the level of health literacy, the less doctors or specialists are consulted).
- A high proportion of the population showed difficulty with organisational, communicative, vaccination and digital health literacy.

Collaboration sees discovery of a new species of bacteria

Professor Colum Dunne, Head of School and Foundation Chair and Director of Research at the UL School of Medicine (senior author and study lead); Dr. Nuala O'Connell, Consultant and UL Adjunct Associate Professor in Clinical Microbiology (co-author) and James Powell, Surveillance Scientist at University Hospital Limerick in conversation with Juanita Guidera, Editor.

How often has your imagination been captured by a new TV series which centres on the discovery of an unknown or ancient pathogen? Perhaps in healthcare we are even more invested because we've seen the potential impact of new discoveries. As research tools become more sophisticated and our curiousity is inspired, who knows what emerging knowledge will mean for us.

While the zombie apocalypse is not yet upon us, researchers at University of Limerick's School of Medicine, working in partnership with University Hospital Limerick (UHL) and Queen's University Belfast (QUB) have discovered a new species of bacteria that is resistant to antibiotics. The species is capable of colonising patients in a hospital setting. It was identified from swabs taken from a patient admitted to one of the hospital's wards as part of a routine safety process.

Colum, can you tell us what did the study entail and what did the researchers discover?

Our research strategy emphasises clarification of real-world problems and seeks solutions. We detected, characterised and identified a novel species of bacteria. This was completed as part of a largescale genomic and microbiology analysis of UHL's wastewater system. The results were correlated with samples taken from patients as part of the hospital's cautious approach to the management of microbiology and infection risk.

The bacterial family, called Pseudocitrobacter, has only recently been classified and we found that our isolate is a new addition to that family. It had not been reported elsewhere and was never isolated from a human sample. This new species is resistant to many commonly used antibiotics, including some that are reserved for resistant bacteria. Fortunately, the patient did not need treatment with these drugs, remaining asymptomatic.

This is an example of innovation with real impact for society. The Limerick group has been working for more than a decade to add to our understanding of microbes and help put systems in place that help to prevent and control outbreaks of infection.

James, why do you think this work is important?

Recent advances in molecular techniques have allowed us to explore the microbial epidemiology of our patients and the hospital environment in ways that we couldn't have envisioned just a short time ago. It was an honour and privilege to be part of the research group that studied this new bacterial isolate.

When asked about the study, Professor Brendan Gilmore, co-author and Professor of Pharmaceutical Microbiology at QUB, said: "This All-Ireland collaboration underpins the importance of cross-disciplinary academic and clinical research in monitoring, identification and control of potential emerging bacterial threats in the healthcare system."

Colum, what enables this work?

Our work has been enabled by a forward-looking approach to infection prevention and the facilitation of research by the hospital's management. Such support is an indicator of a healthcare system focused on best practice for proactive and solution-oriented research that can make a difference.

We were also delighted to have the co-operation and support of the UHL estates team, particularly Larry Murphy, who was instrumental in facilitating the collection of the samples and tracking their location, which allowed the metagenomics data to be mapped within the hospital.

Collaboration of this nature is essential in healthcare. University-based researchers bring expertise and access to sophisticated molecular equipment that, together with the clinical knowledge of hospital-based doctors and surveillance scientists, can help to ensure patient safety is protected.

Nuala, what impact does this work have in healthcare?

It is fortuitous to have access to wonderful academic scientific researchers in UL and Queen's University Belfast who could perform specialist molecular testing to help identify the novel microbe. It has enabled us to understand the potential route of acquisition, which will impact on infection prevention and control strategies.

Colum, what does the future of this work look like?

It is very likely that identification of new bacterial species will happen more frequently. Hospitals internationally are environments where there is heavy use of pharmaceutical products, such as antibiotics, and in that type of ecosystem mutations occur frequently. In our studies of these microbes, we see emergence of new antimicrobial resistance patterns, novel genes, new plasmids - transmissible elements of DNA - encoding for the resistance, and potential for further colonisation of patients.

It is likely that the analysis we performed will become more widely available, less expensive and allow identification of infectious agents more rapidly, possibly even through bedside or point-of-care testing as technology improves.

Why is antimicrobial resistance a concern?

Reducing healthcare associated infection and antimicrobial resistance is a key patient safety priority of the Patient Safety Strategy 2019 - 2024.

Antimicrobial resistance (AMR) is estimated to be directly responsible for over one million global deaths annually. AMR makes infections harder to treat and increases the risks associated with other medical procedures and treatments. Hospital acquired infection, occurs when people who are admitted to hospital for treatment become infected by microbes circulating in the hospital wards.

Access information about Health Care Acquired Infection here.

Where can you find out more about this study?

Email: Professor Colum Dunne: Colum.Dunne@ul.ie
Access artices here:
Journal of Hospital Infection article 1
Journal of Hospital Infection article 2

Beaumont Hospital celebrates wards without an intravascular-device related bloodstream infection in the past 12 months

Giribabu K Muniyappa, Clinical Nurse Manager III, on behalf of IPC team in conversation with Juanita Guidera, Editor

Have you ever been an inpatient in hospital? If so there is a good possibilty that you had an Intravascular device (known commonly as an IV) in your arm for fluids or medicine. You may even have had the joy of navigating how you wore your dressing gown before settling it upon your shoulders like a cape before heading down the long corridor for a walk.

While I've never met someone that said they loved their IV, these devices such as peripheral vascular catheters (PVCs) are an essential part of patient care in acute hospitals. However, there are potential complications, including infection involving the PVC exit site, or in some cases bloodstream infection (BSI). Staphylococcus aureus (S. aureus) is the commonest pathogen causing PVC-related infection.

Giribabu, can you tell us about the work of the IV Team in Beaumont Hospital?

In 2022, a great opportunity to start an intravascular (IV) team service arose for Beaumont Hospital, through a Health Service Executive (HSE) Antimicrobial Resistance and Infection Control (AMRIC) Division-funded initiative. By 2023, Beaumont Hospital's IV Team service was established through the appointment of my role as a CNM3 IV Team and four staff nurses (currently George Kuran, Sarah Curran, Ma Michelle Palomar). To date, we have successfully inserted over 4,500 peripheral vascular catheters (PVCs).

Beaumont Hospital's multidisciplinary infection prevention and control team (IPCT) closely monitors hospital-acquired BSI due to S. aureus, including those BSI due to infection of intravascular devices. It is reported monthly to the HSE as a key performance indicator.

Over the past decade, staff in Beaumont Hospital have implemented a multi-faceted programme to minimise the risk of PVC infections. This has involved the introduction of a PVC maintenance care bundle for every PVC inserted, peer-to-peer audit of compliance with PVC care bundle documentation, feedback of PVC care bundle compliance audit scores, dissemination of surveillance data on hospital-acquired S. aureus BSI to staff, along with multi-disciplinary case review to ascertain whether there have been any potentially preventable contributory factors in the event that a S. aureus BSI arises due to an IV device.

There has also been a strong focus on staff education about the importance of preventing PVC infection, recognition and actions to manage suspected PVC-related infection, the use of aseptic non-touch technique (ANTT®) for accessing a PVC, the 'scrub the hub' technique prior to accessing a PVC, and more recently the introduction of pre-filled saline syringes for flushing of a PVC. IV medications, such as antibiotics should be assessed daily, and switched to oral or tablet versions, where appropriate, as this will facilitate removal of the PVC. Patient education also have an important role to play in preventing PVC-related infection.

So what happens in Beaumont Hospital, if a patient develops a suspected PVC-related infection?

Patient first: A PVC should always be removed at the first sign of PVC infection. If a bloodstream infection (BSI) is confirmed by the laboratory, the clinical microbiology team will inform and advise the patient's primary team about the recommended treatment.

Identify a source: Every case of S. aureus BSI is also discussed at the weekly meeting of the IPCT to establish whether it has been possible to identify the cause of the infection.

Investigate: Where an IV device has been identified as the potential cause of a S. aureus BSI, a case review meeting takes place, involving the patient's clinical team, nursing staff and the IPCT.

The purpose of the meeting is to review the case and identify any potentially contributing causes for the BSI, and most importantly to identify any areas for improvement and whether any further preventative measures can be implemented.

Respond: If an area for improvement is identified, a quality improvement action tracker is commenced on the ward where the PVC-related infection arose. The action tracker is a roadmap for both ward staff and the IPCT to work together to ensure any actions are delivered upon.

Share what we learned: Local surveillance data on hospital-acquired S. aureus BSI and PVC infections, along with the key learning points from case reviews is shared by the IPCT on a monthly basis, across a variety of forums within Beaumont Hospital's governance structure. The learning points and prevention measures are a key part of ongoing staff education around PVC infection prevention.

Pictured below is the Beaumont Hospital, Infection Prevention and Control Team

What has happened since the IV Team service was introduced in 2023?

Beaumont Hospital's IV team records each PVC inserted using a quality management system. The system has been used for undertaking IPC-related audits since 2014. It has been adapted for PVC insertion data, and has been beneficial for service planning.

Currently, the IV Team covers all inpatient areas and the Emergency Department. It has been a great service for patients, and has been warmly welcomed by clinical staff across the hospital.

The main aim of the IV Team is to lead the programme to prevent PVC-related complications, with the focus firmly on the patient. A key benefit of the IV Team service is the provision of consistent verbal and written information to patients about the PVC and the patient's role in prevention and recognition of PVC infection.

The IV Team carefully assesses each referral, because sometimes a PVC is no longer required. Indeed, approximately 1% of referrals to the IV Team have resulted in a PVC not being inserted because it was not required. The IV Team ensures a consistent approach to PVC insertion practice, facilitates audit, develops policies related to PVCs such as facilitating the education of clinical staff on PVC insertion, so that skills are maintained, along with provision of training.

Would you share an example of how this has impacted services?

As of 22nd February 2024, five months have elapsed since the last hospital acquired intra-vascular catheter related S. aureus BSI in the Hospital. There has been a strong commitment to PVC-related infection prevention as an important patient safety initiative across the Hospital, as staff acknowledge that the vast majority of PVC-related S. aureus BSI are preventable and should be regarded as a 'never event' in patient care.

How do you acknowledge important milestones?

To celebrate the multi-disciplinary efforts of staff who manage PVCs and prevent PVC infections, the IV Team launched a new initiative in 2024 to mark 'Never Event' anniversaries. This is an opportunity to acknowledge the staff on wards that have recorded no S. aureus BSI due to an intravascular device in the past year.

This year, a certificate of achievement was presented to each ward in Beaumont Hospital that achieved the milestone in a ceremony event attended by our Director of Nursing, Nursing Management Team, Director of Quality and Patient Safety, and the IPCT. It was a wonderful afternoon of celebration and an opportunity to acknowledge the great care given to patients of Beaumont Hospital.

- **Pictured above is the Adams McConnell ward (Celebrating one year of NO hospital acquired IV device related SABSI)**

- **Pictured above is the AMRIC team visit on the occasion of 1000 PVCs successfully inserted in May 2023**

- **Pictured above Giribabu K Muniyappa (IV Team lead/CNM3), Caoimhe Finn (ADON, IPC), Prof. Karen Burns (Consultant Microbiologist), Ma Michelle Palomar (IV Team-Staff nurse) and George Kurane (IV Team-Staff nurse)**

Where can you find out more information?

To find out more you can email:
Giribabu Kalukondanahally: giribabukmuniyappa@beaumont.ie

Spark Innovation Programme

Catherine Marsh shares the latest on innovative projects from Spark Initiatives

What is the Spark Innovation Programme?

The Spark Innovation Programme is a frontline, staff-led initiative that seeks to support, promote and recognise innovation amongst healthcare staff. The Health Services People Strategy 2019-2024 sets out a vision of an exceptional employee experience that engages the talent and nurtures the leadership capability of all individuals and teams working together to deliver safer, better healthcare.

The Spark Programme was initially established as a national programme to empower and engage doctors at the beginning of their careers. The power of this vision has seen Spark expand in recent years to include all healthcare professionals, and every employee of the HSE. This has been achieved with partnerships and ongoing support from the Office of Nursing and Midwifery Services Director (ONMSD), National Doctors Training and Planning (NDTP), and the National Health and Social Care Professions Office (NHSCPO).

Each year the Spark Innovation Programme offers National Innovation Fellowships across the clinical disciplines represented by the NDTP, ONMSD and HSCP. The fellowship allows the clinician working at the frontline an opportunity to enter into an immersive, 'action learning' environment.

Spark Initiatives

We, at HSE Spark Innovation Programme, accept applications from healthcare workers across the healthcare system 365 days a year. If you have an idea that you believe will bring value to your patients, your colleagues and the health service at large, apply for one of our initiatives.

Visit www.hse.ie/spark for details.

CLICK HERE

Hear from current Nursing Fellow Catherine Marsh

"My name is Catherine Marsh and I am the Nursing Fellow for HSE Spark for 2023-2024. Being a nursing fellow for innovation can offer a range of unique and rewarding experiences. Here are some of my highlights:

- **Innovative Problem Solving:** I have the opportunity to tackle complex healthcare challenges using creative and forward-thinking solutions. This role involves thinking outside the box and developing novel approaches to improve patient care, enhance healthcare delivery and address systemic issues.
- **Collaboration and Networking:** Innovation in healthcare requires collaboration across all disciplines. As a nursing fellow, I am fortunate to have the chance to work with professionals from diverse backgrounds, including other healthcare providers, engineers and designers. Building these networks has enhanced my skills and broadened my perspective on healthcare.
- **Professional Development:** Being a nursing fellow has allowed me to expand my skill set beyond my traditional nursing roles. I'm currently studying for a Professional Diploma in Service Design with NCAD. I have gained experience in project management, data analysis, technology integration, and other areas crucial to driving innovation.
- **Leadership Opportunities:** I plan to lead on a project that I've been working on prior to my fellowship role, to implement photo documentation for physical injuries for people who attend the Sexual Assault Treatment Units. Initial evaluation will be in Rotunda Hospital, Dublin commencing in early 2024.

The nursing fellow for innovation with HSE Spark innovation programme, has been a unique opportunity for me as a nurse in clinical practice. I hope over the next six months to emerge as a nursing trailblazer, passionate about driving positive change in the ever-evolving healthcare landscape. It's a year I plan to learn, lead and guide myself and others about what innovation is."

Pictured from left to right, front row: Neha Chandra, Communication Officer; Dr Bobby Tang, NCHD Fellow. Second row: Caitriona Hefferan, HSE Spark Innovation Lead; Dr. Michelle Howard, HSCP Fellow; Catherine Marsh, Nursing and Midwifery Fellow; Jared Gormly, Head of HSE Spark Innovation Programme; Dermot Burke, HSCP Fellow.

Looking to the future: Spark 2024

Spark Connect

During Public Sector Transformation Week 2023, our fellows, Michelle (HSCP fellow) and myself, introduced 'Spark Connect', a pioneering initiative designed to catalyse innovation and collaboration in healthcare settings across Ireland. Throughout the week, teams from every county across the country participated in innovation sprints that challenged them to reshape or rethink services in both inpatient and outpatient care settings.

The week kicked off with a compelling online session, "Interviews with Innovators," exchanging success stories and their experiences of delivering healthcare innovation projects nationwide. Frontline staff members from the Health Service Executive shared their innovation journeys, bringing to light the real-life impact within their roles. As a commitment to empowering frontline staff, the first ever 'Spark Connect Toolkit' was distributed, unlocking innovation potential and fostering creative solutions for enhanced healthcare delivery.

Spark Summit 2024

Spark Summit is a unique health innovation conference for healthcare staff, industry and academics. The summit focuses on the exciting innovations that are transforming the ways that we provide care. We are all set for another annual Spark Summit on the 24th June 2024, Mansion house, Dawson Street, Dublin. For early bird tickets, contact Spark@hse.ie. If you or a colleague has undertaken an innovation project that you feel should be recognised by the HSE Spark Innovation Programme through our 'Bright Spark Award' programme, let us know by writing to us at spark@hse.ie.

Our 2024 Fellowship Applications

APPLY NOW

Are you interested in becoming a National Innovation Fellow in 2024? Applications for the NCHD are now closed and keep an eye on our social media for the HSCP's and Nursing / Midwifery Fellowship opening dates!

For further details visit www.hse.ie/spark. We are excited for you to join the HSE Spark family and contribute to the world of innovation.

CEO Bernard Gloster presenting the 2023 Spark Ignite award to winner Dr. Patsy Lenane, Consultant Dermatologist, Mater Misericordiae University Hospital

Caitriona Hefferan, HSE Spark Innovation Lead; Dr. Colm Henry, CCO, HSE; Dr Rachel McNamara, NCHD fellow 2022-2023; Jared Gormly, Head of HSE Spark Innovation Programme

2023 Health Service Excellence Awards

with Marie O'Sullivan, HSE National HR

One of the concepts in healthcare improvement is positive deviance. How can we learn from those people who do it well? Events like the 2023 Health Service Excellence Awards enable us to see examples that made a difference and expand our knowledge.

2023 was the seventh year of the Health Service Excellence Awards. The Awards are an opportunity for projects or initiatives in any area of the public health service to demonstrate and gain recognition for the teamwork, collaboration and engagement in the development of a patient-centred integrated care / improvement project. The Awards process celebrated the energy, flexibility and commitment of our staff in the provision of a public health service.

In 2023, 10 Finalists in each category went forward to meet with the Selection Panels. The five Selection Panels were chaired by members of the HSE Board People and Culture committee. This was an opportunity for the members of the HSE Board People and Culture Committee to work with senior managers in the HSE on the panels. It was also an opportunity to meet with and receive the presentations from the finalists delivering services to our community.

Every year the Health Service Excellence Awards receives a high number of entries. 2023 was no different with 405 entries. There were five category winners.

The Awards are a valuable reminder of the care and compassion that define the spirit of the public health service and those who work in it. Entries received spanned clinical services, primary care, family support services, and catering, security, management and information technology initiatives - and came from all areas of Ireland.

Winners of the 2023 Health Service Excellence Awards Categories

Engaging a Digital Solution, Older Person and Digital Health Team CHO1
Aislinn Gannon | Community Healthcare Bed Utilisation Application

Innovation in Service Delivery, South/South West Hospital Group
Prof Mark Corrigan and Grace Reidy | Operationalising a Perioperative Initiative across the SSWHG

Right Care Right Place Right Time, Sligo Leitrim Mental Health Services
Dr Elizabeth Gethins | Development of a Crisis Resolution Team

Improving Patient Experience, University Maternity Hospital Limerick
Maria Gibbons | The Lavender Clinic

Excellence in Quality and Patient Safety, Childrens Health Ireland, Crumlin
Wesley Mulcahy | Complex Care Coordination - Transferable Model of Care for Rare Disease

Pictured left are the category winners.

Where can I find more information?
Watch a short video on the 2023 winners.

National Centre for Clinical Audit talks clinical audit -

What's the hook to get you interested in and doing clinical audit?

Majella Daly, Assistant National Director, National Centre for Clinical Audit shares information about the work of the NCCA team and how they are adapting to better support services in clinical audit

After working for several decades in the Irish healthcare system, I firmly believe the staff who come to work every day want to do a good job, care for the patients or clients they are responsible for and go home at the end of their shift with satisfaction knowing that they have done the best they could.

There's lots of ways to get this assurance, feedback from the services users, their families, staff you work with. However clinical audit offers another method to objectively assess what staff are doing against evidenced based standards and most importantly help to identify what they need to do to change and make improvements for better outcomes. The benefit is that it's not a once-off event, the clinical audit cycle is continuous, measure, improve, measure again, improve some more. Any improvement is good!

When I first started doing Clinical Audit, it was in its infancy in Ireland. The benefit for me as a radiographer in a busy Radiology Department and later in management roles, was that I had solid data to show how my service was complying with standards and also provide evidence where resources were required to help make improvements. Not all improvements require resources, they often require changes in how things are done, bringing the team along with you, enabling staff themselves to come up with the ideas for improvement, changing a culture.

Follow us on X (Twitter) to stay up-to-date on the latest in clinical audit

Pictured above are Ronan Buckley, Clinical Audit Facilitator and Niamh Kennedy, Clinical Audit Facilitator

So while as Assistant National Director for Clinical Audit I have responsibility for National Clinical Audit programmes and advising on local audit, change and improvement can only be achieved using a whole system approach. There are staff and resources available to assist healthcare staff, both in the National Quality and Patient Safety Directorate e.g. QPS Connect, Quality Improvement, Health Intelligence, Incident Management and Open Disclosure and local quality / safety teams where they are available. The NCCA team support and train in clinical audit, and we also sign post to the many other resources that are available for you at a local and national level and work with those teams to enable you do the best possible job.

Having worked through the evolution of quality in Ireland over the past four decades, the greatest change I have witnessed is the development of real partnerships with the users of our services.

How much richer our services can be by listening to what the thousands of people who use our services every day have to say. By walking in their shoes we can truly understand what they need and expect. We don't always meet the standards but by including them on our measurement journey they can give us valuable insights to measure what's important, improve what's important and keep improving. Don't we all want that, aren't we all health services users at some point in time of our lives so I am truly humbled by the work our patient and public Involvement reps do for clinical audit and for other quality improvement programmes.

Our aim is to make clinical audit as accessible as it can be.

The NCCA is also listening to staff. I worked until recently in operational management roles, I have experienced first-hand the competing priorities staff face every day. Our aim is to make clinical audit as accessible as it can be to staff and the NCCA are planning for how we can make that happen. Our first step is to help re-establish the **Irish Clinical Audit Network (ICAN)**, a support network for anyone who is involved in clinical audit and QI.

Karen Reynolds, HSE NCCA

How can you join this network?

Complete our short survey for more details about this joining this network

LEARN MORE

Patient Safety Act

Latest updates from Lorraine Schwanberg,
Assistant National Director for Quality and Patient Safety

Commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 is expected in **summer 2024** (an exact date is to be determined by the Department of Health).

In preparation for commencement, the HSE Implementation Working Group is developing a number of resources to help staff and services. There will be an e-learning programme available for all staff on the Act and documentation templates prepared to help staff when they need them.

There will be regular communication and engagement on the topic leading up to its commencement date, including the webinar series organised by the Open Disclosure staff of the Quality and Patient Safety Incident Management team of the National Quality and Patient Safety Directorate.

The key areas for services and staff to focus on in the lead-up to implementation currently are:

- **The role of the Designated Person -** There will be a legal requirement for the nomination of a designated person to support the families/patients affected by a notifiable incident. This role is a very important support role and organisations should be clear on who fulfils this role locally when an incident occurs.
- **Notifying the Regulator -** The Act requires health service providers to notify the relevant regulator through the National Incident Management System (NIMS) when one of the 13 notifiable incidents is identified. Organisations should be considering who will actually undertake the role of notification within their service and what the local process for this will be.
- **Staff support and culture -** We understand that being involved in an incident can be difficult for all. Responding to a notifiable incident may seem additionally daunting. We know that good communication in a transparent way is key in maintaining trust with those affected. Staff should be supported following an incident to ensure their well-being needs are met and those staff undertaking open disclosure should be supported to do so in an open manner. A culture of openness and transparency, and restorative justice should already be nurtured at all levels of the organisation.

Where can you find more information?

Watch Now

View our latest Open Disclosure webinar:

"Patient Safety Act: overview of the key provisions."

Patient Safety Together: learning, sharing and improving

Latest from Patient Safety Together

Patient Safety Together (PST) is the sharing of learning component of the patient safety programme to support the HSE Patient Safety Strategy. It is coordinated by the Quality and Patient Safety Incident Management Team (QPSIM) of the National Quality and Patient Safety Directorate (NQPSD)

Outputs are shared on this freely available online platform that enables all users to access and download new and up-to-date quality and patient safety information.

New HSE National Patient Safety Alert: Sepsis in Children and Young People

Sepsis / Septic shock can cause significant morbidity and mortality in paediatric and young adult patients. Early recognition and treatment are vital to improving patient outcomes. Recent reviews of children and young people presenting with sepsis have highlighted the challenges of recognising and responding to sepsis in busy and overcrowded emergency settings. This is a safety critical HSE National Patient Safety Alert (NPSA) (released 20th December 2023).

New Patient Safety Supplement: Early recognition and treatment of sepsis

This Patient Safety Supplement provides guidance to all healthcare staff regarding the importance of early recognition and treatment of sepsis to improve patient outcomes and consistency in practice. This includes primary care, community and pre-hospital settings, Emergency Department and in-patient settings. It includes specific references to sepsis in children and young people and sepsis in pregnancy.

NEW HSE Patient Safety Digest now available

This edition of the digest includes a collection of 20 articles and one report that relate to QPS, and two Direct Healthcare Professional Communications containing important new medicine safety information approved by the Health Products Regulatory Authority (HPRA). The information and learning shared in these publications are relevant to anyone with an interest in improving patient safety in our health services.

New Spotlight Series

The Spotlight Series will highlight different patient safety initiatives, examples of local shared learning and/or patient safety content that may impact the wider healthcare audience in Ireland.

In this instalment we shine a spotlight on the national health literacy initiative spear-headed by Patients for Patient Safety Ireland (PfPSI). In January 2024, PfPSI launched a major National Health Literacy Initiative with an open letter to the Ministers for Health, Education, Further and Higher Education and Minister of State for Children, Equality, Disability, Integration and Youth.

Where can you find more information?

- Access: www.hse.ie/pst
- Email: patientsafetytogether@hse.ie.
- View: QPS TalkTime Patient Safety Together - A Piece of the Puzzle to find out more about PST.

HSE launches new Sepsis campaign

Bláthnaid Connolly, Programme Manager, National Clinical Programme for Sepsis in conversation with Juanita Guidera, Editor

92% **of people have a strong awareness of the word 'sepsis.'**

44% **only 44% of people are aware of the signs and symptoms of sepsis.**

37% **only 37% of people aged 65 and older are aware of the signs and symptoms of sepsis.**

When I first heard the symptoms of sepsis, my initial thought was that they did not sound life threatening. When I heard that one in five people with sepsis dies and that more people die from sepsis in Ireland each year than heart attack, my outlook changed. I read the symptoms again and began to wonder if a family member was unwell, would I have been more likely to say, 'give it time' or 'lets talk to the GP'.

"You're right, a lot of people are not aware of the signs and symptoms and our recent research shows this," Bláthnaid says. "Many of us will know someone who has had sepsis, but in a recent study, almost half of the people (44%) said they would not know the sepsis signs and symptoms. Increasing knowledge of the signs and symptoms of sepsis among the general public is an essential part of changing patient outcomes. As part of the ongoing work to increase knowledge, the HSE launched a national public information campaign on the 7th March 2024. The campaign includes radio ads, social media and paid search ads, as well as press and media activity."

What is our understanding of sepsis?

Research completed in preparation for the national campaign found that the symptoms of sepsis are easy to dismiss, miss or mistake. This can lead to a lack of seriousness and urgency in seeking help.

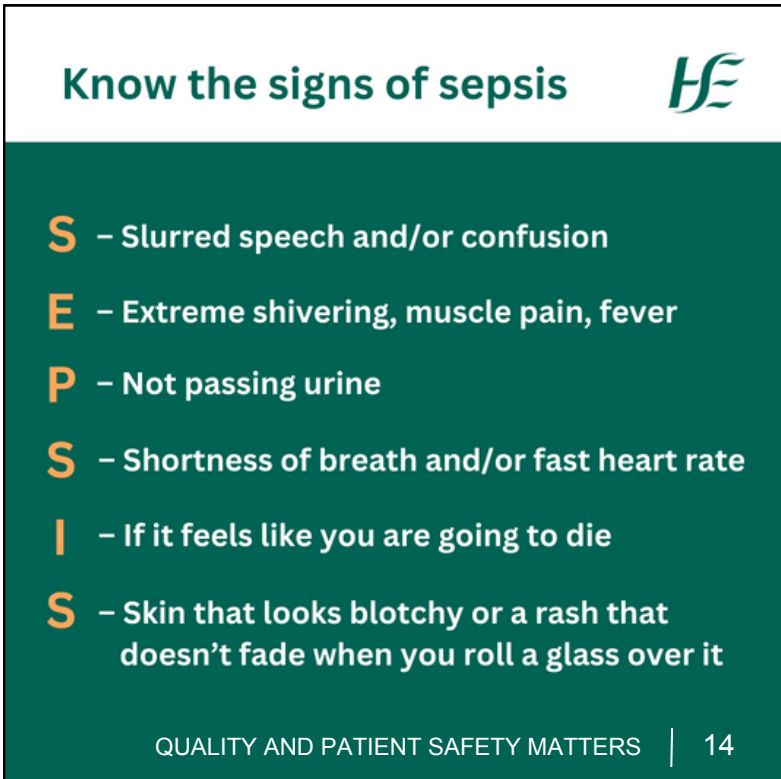
While people broadly understand that to develop sepsis you must have an infection first, they have a narrow view on what that infection could be. This is most likely based on legacy associations (for example, that people only develop sepsis through an infected open wound). There was also a narrow perception of who sepsis can affect.

As part of the research for this campaign, the team also engaged with people who have been affected by sepsis, including those who have lost loved ones to sepsis. Their input and support of the campaign have been invaluable.

How did the research inform the campaign?

The research provided important insights that helped to form our communications approach and seek to address knowledge gaps. The campaign aims to increase knowledge of the signs and symptoms of sepsis, increase understanding of the risk of sepsis and encourage health-seeking behaviours when someone suspects sepsis.

We are using radio ads and social media ads as our primary communications channels. Radio is a suitable channel for reaching people aged 65 and over, where the majority of cases and deaths from sepsis occur. Social media allows us to target different age groups, amending messages as required, for example symptoms are different for children. We will continue to raise the importance of knowing the signs and symptoms through media interviews and the Walk and Talk Improvement Podcast.



Role of healthcare professionals

Many healthcare professionals know that sepsis is a time-sensitive, life-threatening illness. The role of healthcare professionals is vital in identifying sepsis and taking steps to manage the condition at an early a stage as possible. The following resources are designed with healthcare professionals and subject matter experts to support you in your work.

Listen to patients, parents and carers who ask "**could this be sepsis?**"

Clinical Resources

Assessing whether or not an adult or child is at risk of sepsis starts with a suspicion of infection.

The sepsis clinical webpage is a dedicated resource for comprehensive insights into the diagnosis, management and timely treatment of sepsis. Here you will find the latest sepsis guidelines for adults, maternity and paediatric, with practical tools to enhance your understanding and expertise in addressing this critical medical condition.

A diagnosis of sepsis should be considered in any patient that presents to a healthcare facility with an acute illness or experiences clinical deterioration as a hospital inpatient that may be due to infection.

Please find resources on our website.

Training programmes

The National Clinical Programmes for Sepsis has two online sepsis training courses on HSeLanD. The two courses are:

- **The 'Introduction to Sepsis Management for Adults including Maternity'**
- **'Recognition and Management of Sepsis in Children'**

These programmes are designed for nurses, midwives, doctors, HSCPs and undergraduate students working in acute care areas. The training is mandatory for nurses, midwives and doctors in all hospital groups. The courses may also be beneficial to other healthcare workers involved in patient care including Healthcare Assistants.

Irish National Early Warning System

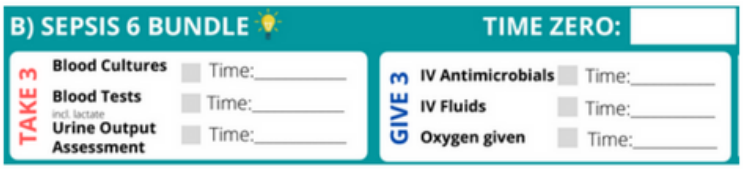
The Irish National Early Warning System (INEWS) is a prompt to check for sepsis. The Sepsis Form (Clinical Decision Support Tool) should be used for patients who have a suspicion of or confirmed infection with an INEWS score of ≥ 4 or ≥ 5 on supplementary oxygen (or <4 or <5 for elderly or immunocompromised patients) and who meet one of the following criteria:

1. **at risk of neutropenia**
2. **have evidence of organ dysfunction**
3. **have a ≥2 SIRS plus ≥ 1 comorbidity**

Sepsis six bundle

If sepsis is suspected following medical review, this is Time Zero and the Sepsis 6 bundle should be completed within 1 hour. This involves Take 3 (cultures, bloods including lactate, urine output) and Give 3 (IV fluids, antimicrobials, oxygen). However, if you are concerned about a patient, escalate care regardless.

If there is a clinical suspicion of infection and the child appears unwell, the Paediatric Sepsis Form should be initiated. Broad categorisations of high-risk criteria (red flags) and intermediate risk criteria (amber flags and risk factors) are displayed algorithmically to empower the clinician to act promptly and commence the Sepsis 6 protocol in a timely manner.



Public Resources

New sepsis leaflets were developed in 2023 with information on the signs of sepsis for adults, children and maternal sepsis. They are available to order from healthpromotion.ie - search by topic for 'Sepsis'. The leaflets are also available to download in ten different languages.

Where can you find more information?

Click on the website

Email: Bláthnaid Connolly, Programme Manager, National Clinical Programme for Sepsis **sepsis.team@hse.ie**

2024 Prospectus of Quality and Patient Safety Education and Learning Programmes

When you work in healthcare, time for continuous professional development is precious. The 2024 Prospectus of Quality and Patient Safety Education and Learning Programmes is here to help you discern how best you can use that time to further develop your skills.

Published by the National Quality and Patient Safety Directorate, this annual prospectus will help you identify key learning programmes that will support you in your day-to-day work to improve quality and patient safety and in planning your personal or professional development.

Many of our programmes are also eligible for CPD credits from RCPI, NMBI and CORU. You will find out more beside each programme.

What do you need to know?

This prospectus provides information about the education and learning programmes available to staff, students and patient partners through e-learning, virtual learning and face-to-face workshops. Our programmes cover key areas relating to quality and patient safety such as:

- Reducing Common Causes of Harm
- Incident Management
- Open Disclosure
- Quality Improvement
- Data for Decision Making
- Clinical Audit
- Human Factors

This year we are pleased to include contributions from our colleagues :

- The HSE Spark Innovation Programme
- Lean Academy
- National Complaints Governance and Learning
- Governance and Risk
- National Safeguarding Office
- Children First National Office
- Antimicrobial Resistance and Infection Control (AMRIC)
- Delivering Change in Health Services
- HSE Libraries.

What did people say

Welcoming the prospectus, Dr. Orla Healy said:

"I am delighted to share with you the 2024 Prospectus of Quality and Patient Safety Education and Learning Programmes and we look forward to welcoming you onto one of our programmes in 2024."

Dr. Orla Healy,
Clinical Director of the National Quality and Patient Safety Directorate

"I am encouraged to see a real commitment by the HSE by involving patients in the design and delivery of their education programmes."

Ashling O'Leary, Patient Partner,
Patients for Patient Safety Ireland

"For me, this is a great resource in that it brings together all the learning programmes and resources which are available to staff to help them build their own knowledge and skills around improving quality and patient safety."

Angela Carey,
Quality and Patient Safety Manager,
University Hospital Waterford

Who are we?

The National Quality and Patient Safety Directorate (NQPSD), led by Dr. Orla Healy, work in partnership with the regions, patient representatives and other partners to improve patient safety and quality of care.

Everything we do is anchored in the Patient Safety Strategy 2019-2024.

We want to hear from you!

We want to hear how the Prospectus has helped you in planning your quality and patient safety learning during 2024. Email us at qps.education@hse.ie to share your thoughts.

Where can you access the prospectus?

Access the 2024 Prospectus on our website.

QPS TalkTime what's new?

Interested in how behaviour impacts safety? The QPS TalkTime Civility Saves Lives session had excellent feedback on practical tips and guidance for staff on civility in the workplace.

Watch back a recording of experts Dr. Chris Turner and Professor Eva Doherty for the QPSTalkTime Webinar "Civility Saves Lives".

The NQPSD YouTube Channel also hosts past QPS TalkTime webinars on everything from psychological safety, leadership, major causes of harm and so much more.

Join us for our upcoming sessions

- 5th March 2024: Creating networks for patient safety
- 7th March 2024: QPS TalkTime Special Live from the International Collaborative
- 19th March 2024: Quality improvement in practice - Lead NCHD Programme
- 9th April 2024: Person Centred Lean Six Sigma Model in patient safety
- 23rd April 2024: Paediatric Sepsis
- 14th May 2024: Medication Safety
- 28th May 2024: Just Culture
- 11th June 2024: Clinical Audit

Latest episodes of Walk and Talk Improvement:
Ideas for safe quality care

Subscribe to our mailing list to stay up-to-date on all things quality and patient safety.

SUBSCRIBE

Are you looking for ways to improve your quality and patient safety knowledge but short on time? If so the Walk and Talk Improvement Podcast may be of interest. Listen while out for a walk, washing up or commuting! Available free via Acast, ITunes, Spotify or wherever you get your podcasts.

Episode 9 | Deconditioning: Patient Harm Hidden in Plain Sight

Deconditioning is a harm hidden in plain sight. It may be 10 or 100 times more prevalent than falls or pressure ulcers. In this episode of "Walk and Talk Improvement" we discuss how through deconditioning, we are unintentionally "killing patients with kindness".

Featuring:
- Professor Brian Dolan, OBE, Director, Health Service 360
- Deirdre Lang, Director of Nursing/National Lead for Older Persons Services, Office of the Nursing and Midwifery Services Director, Health Services Executive
- Caroline Lecky, Nurse Consultant for Care homes, Public Health Agency, Northern Ireland

Hosted by: Dr Maureen Flynn Director of Nursing, QPS Lead | National Clinical Programmes Liaison CDI & ONMSD | National Lead Nurse Referral for Radiological Procedures, HSE.

Episode 10 | Part 2: Bearing Witness: through life and death

In this episode of Walk and Talk Improvement, we continue the conversation on patient partnership. Guests Mary Vasseghi and Christine Fenton share an insight into their lives, motivation and experience as patient partners. Through their stories, we explore what you can do to have meaningful and real engagement with patient partners.

Featuring:
- Mary Vasseghi, Patient Partner, Patients for Patient Safety Ireland
- Christine Fenton, Patient Partner and Service User

Hosted by: Juanita Guidera, Programme Manager - Staff Engagement for Quality, National Quality and Patient Safety Directorate, HSE.

Episode 11 | Embracing the Unknown: In conversation with Professor Helen Bevan

How can we successfully engage with patients and staff to improve safety? In this episode, we speak with Professor Helen Bevan about her journey to become an internationally renowned improvement and change expert. Through her extensive experience we explore how engagement, creativity and innovation can improve safety and quality of care. We hope this episode inspires and encourages you in your own work.

Featuring:
- Professor Helen Bevan

Hosted by: Juanita Guidera, Programme Manager - Staff Engagement for Quality, National Quality and Patient Safety Directorate, HSE.

Coming soon: Episodes 12 and 13 on Sepsis - what do you need to know as a healthy person, patient, carer or parent? and Sepsis - for healthcare professionals.

Shaping safer healthcare:

The Improvement Collaborative Handbook

Alison Dwyer shares how the Improvement Collaborative Handbook can be used on your next improvement project

Are you thinking of starting an improvement collaborative with your service? If so, the Improvement Collaborative Handbook is here to help. Drawing from over a decade of expertise from the National Quality and Patient Safety Directorate, our work with services and other subject matter experts, our handbook is an Irish-specific adaptation of the successful Breakthrough Series Collaborative Model from the Institute for Healthcare Improvement. We designed the handbook to be versatile and applicable across all healthcare sectors, including both clinical and corporate settings.

Inside the handbook

The handbook is a comprehensive step-by-step guide for organising and leading collaboratives, with worked examples from previous successful initiatives. Incorporating toolkits, templates, and resources ensures the approach is data-driven and results-focused. Moreover, it presents tried-and-tested methods to tackle challenges across healthcare sectors, making it a practical tool for real-world application.

What is an improvement collaborative?

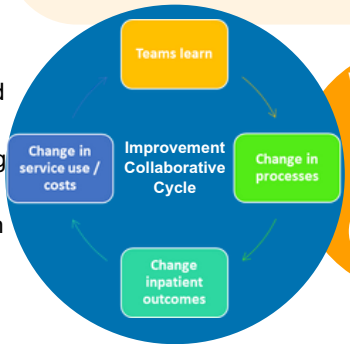
An improvement collaborative is a systematic approach to quality improvement (QI) where we test, measure, and share innovative practices. This model has been successfully employed internationally for over two decades, proving its worth as a strategy for using QI methods and approaches.

Why quality improvement?

QI is more than a concept. It is an evidence-based systematic approach to understanding and enhancing processes and systems. As highlighted in the handbook, the Model for Improvement helps services overcome common barriers to quality care, even amidst resource and staffing constraints. **The ultimate goal? To pinpoint improvement opportunities and design sustainable solutions.**

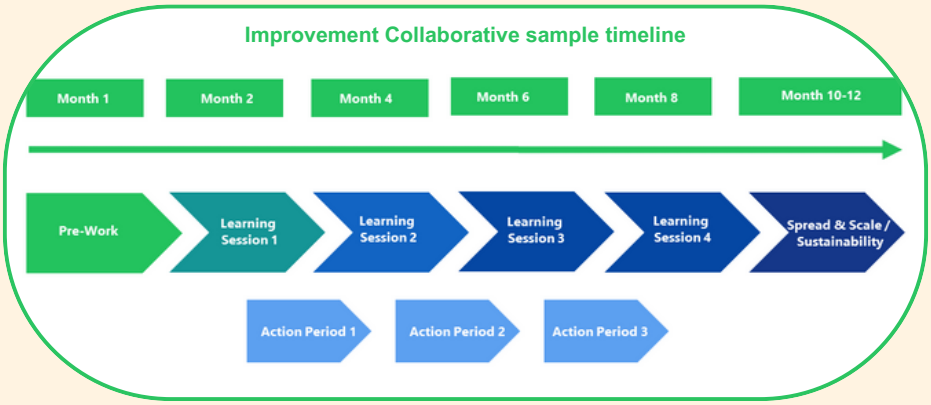
How does an improvement collaborative function effectively?

Improvement collaboratives offer a structured approach that supports individuals, teams, and systems simultaneously. The core activities involved are team-based learning sessions, identifying and testing changes for improvement, continuous sharing of ideas, and focusing on important quality or safety goals. These elements combined lead to changes in patient outcomes, service use and costs.



Phases and timeline

An improvement collaborative typically spans 10-12 months with a series of learning sessions, action periods, and evaluations. This timeline, while flexible, provides a structured pathway towards achieving the set goals of the Collaborative.



Empowering local ownership

Central to the success of improvement collaboratives is local ownership. Our handbook emphasises that collaboratives should be coordinated and driven by those within the service, engaging staff to tackle local challenges creatively.

QPS Improvement and Dublin Midlands Hospital Group's Testing In Action

Our work doesn't stop there! We are delighted to be working with Dublin Midlands Hospital Group (DMHG) in the testing in action of our Improvement Collaborative Handbook. DMHG has embraced the handbook for two significant initiatives to address common causes of harm outlined in the HSE's Patient Safety Strategy, 2019-2024. We actively support DMHG's journey, providing skills and knowledge through tailored online and in-person workshops for collaborative and site leads. Our fortnightly support meetings with collaborative leads are dynamic exchanges fostering progress and sharing best practice. Crucially, we continuously collect user feedback to advise the next version of our handbook.

I'm interested in carrying out an Improvement Collaborative within my service - how do I go about it?

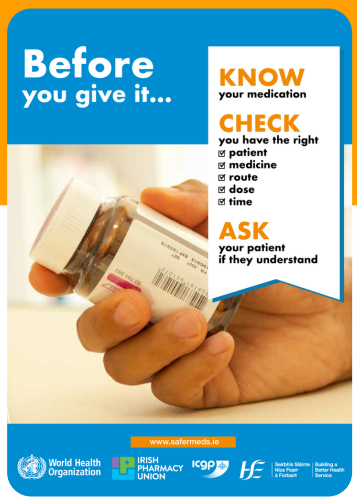
That's great! Improvement collaboratives can play a major role in addressing high-priority patient safety areas, spreading best practice and supporting quality improvement. They can also help spread knowledge and innovation, as well as develop members' abilities to make and test changes in healthcare. As a starting point, read the 2-page handbook summary on the National Quality and Patient Safety Directorate website or download the complete handbook. You could also discuss quality improvement initiatives in meetings and connect with local QPS leads.

Where can you find further information?

Find both the improvement collaborative summary and handbook on our website.

To learn more, contact the team by email at QPS.Improvement@hse.ie.

Know, Check, Ask



Did you know that unsafe medication practices and medication errors are a leading cause of injury and avoidable harm in healthcare systems across the world?

In Ireland, adverse drug events are the third most common type of adverse events and 8.8% of emergency admissions are related to medicines. **Most medication errors are avoidable.**

The aim of the WHO third Global Patient Safety Challenge, "Medication without Harm," is to reduce severe avoidable medication-related harm by 50% globally in the next five years. Know, Check, Ask is a medication safety campaign developed to support the Challenge. The campaign uses a three-step approach to help increase awareness of medication safety among the public and healthcare professionals.

When you prescribe, dispense, prepare or administer a medicine, it is important that you follow these three steps:

1. **Know** the medicine.
2. **Check** that you have the right patient, medicine, route, dose and time.
3. **Ask** the patient if they understand.

When you take the time to follow Know, Check, Ask every day, you will reduce severe avoidable medication-related harm and ensure the patient's medication journey to be as safe as possible. This will also help healthcare professionals to follow the guidance issued by their regulator on medication management and administration. By promoting this message widely, you will also encourage those taking medication and their caregivers to take a more active role in their medication.

An eLearning package called 'Medication Without Harm' is available on HSELand which will help you reduce severe, avoidable medication related harm by applying the concepts of Know, Check, Ask and person-centred care.

What can I do next?

- Access Know, Check, Ask resources on www.hse.ie/safermeds.
- Display posters, especially Poster F, in clinical areas where medicines are prepared or stored.
- Include Poster F as a screensaver for devices used in clinical areas.
- Complete 'Medication Without Harm' eLearning on HSELand.
- Include Know, Check, Ask message at team meetings and staff induction.

We all have a role to play in medication safety.
Please join us in achieving Medication Without Harm!

Have you heard of My Medicines List?

My Medicines List is a list of all the medicines and supplements you take.

Why should I use it?

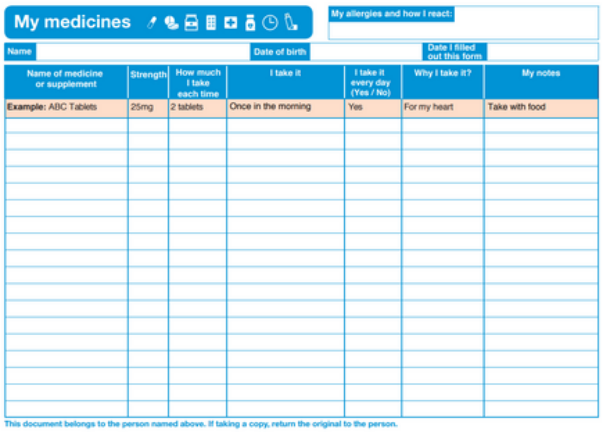
Keeping an up-to-date list can help you know your medicines. It can also help you when discussing your medicines with a healthcare professional.

How should I fill it in?

To fill out My Medicines List, you need all your medicines in front of you. Another option is to ask your pharmacist to print out a list for you. Make sure you include all prescribed and over-the-counter medicines and supplements.

How should I use it?

Keep your list up to date. Bring it with you when attending any healthcare appointment. You may find it useful to keep a photo of this list on your phone.



Print a copy from our website.

You can also ask for a copy at your local pharmacy.

Where can I print my form?

Leabharlann Sláinte na hÉireann
Health Library Ireland
Ár nAcmhainn Náisiúnta | Our National Resource

HSE Open Access Awards

Celebrating Open Access

The HSE Open Access Research Awards were established in 2014 to encourage and reward open access publishing in the Irish health sector.

Submissions are open to a range of disciplines in health and social care.

About the Awards

The awards build on the HSE's statement on Open Access publishing and the commitment to develop and promote open research. The award recognises health and social care professionals and those conducting research in the Irish health system.

It is a route to promote research activity that improves the evidence and knowledge base underpinning our health services.

What is open access?

Open access (OA) refers to free online access to scientific and scholarly information allowing published academic research to be freely available.

In OA authors retain all intellectual property rights to their work, and make it freely available for everyone to read and use. HSE Libraries encourage health researchers working in Ireland to share their work via Lenus.

What is Lenus?

Lenus is the leading source for Irish research in health and social care. Lenus collections include peer reviewed journal articles, grey literature, dissertations, reports and conference presentations.

Lenus contains the publications of the HSE and the collected research output of over **130 health organisations**, past and present, **and are all freely accessible**.

Pictured above are Professor Jonathan Drennan, UCD; Laura Rooney-Ferris, Library Resources Manager, HSE Libraries; Padraig Manning; Librarian and Lenus Repository Manager, HSE Libraries.

2023 overall winner Open Access Awards

Winning journal article: "Applying a new approach to the governance of health care quality at board level"

The 2023 Overall Open Access winning paper focuses on how using data in the right way can enhance oversight of quality and patient safety at board and senior management team level. The paper describes a quality improvement project undertaken with the HSE Senior Leadership Team to improve oversight of quality and safety at national level.

Using co-design and applying the "Picture-Understanding-Action" approach, the project team supported the HSE senior leadership team to identify and test a qualitative and quantitative picture of the quality of care across the health system.

1. A "Quality Profile" consisting of quantitative indicators, analysed using statistical process control (SPC) methods was used to provide an overview of the "critical few" indicators across health and social care.
2. "People's experience of quality" shared patient, service user, family and front-line staff experiences which add depth and context to the data.

The project led to quality of care being prioritised and interrogated at board level and was transitioned to the HSE Board's Safety and Quality Committee. Read the full paper.

Authors

- **Jennifer Martin,** Director of National Health Service Improvement, Public Health, HSE
- **Zuneera Khurshid**, Research Fellow, UCD Centre for Interdisciplinary Research
- **Gemma Moore,** Qualitative Research and Evaluation, NQPSD, HSE
- **Michael Carton**, Principal Epidemiologist, Health Protection Surveillance Centre, HSE
- **John J. Fitzsimons**, Clinical Director, NQPSD and Consultant Paediatrician, Children's Health Ireland at Temple Street.
- **Colm Henry**, Chief Clinical Officer, HSE
- **Maureen A. Flynn**, Director of Nursing, Office of the Nursing and Midwifery Services Director, HSE

This paper was submitted while the team was part of the National Quality Improvement Team.

Pictured left are Dr. Phillip Crowley, National Director, Strategy and Research, HSE presenting the award to Dr. Jennifer Martin and Dr. Gemma Moore at the 2023 Open Access Awards. In the background (from HSE Libraries) Aoife Lawton, National Health Service Librarian; Laura Rooney-Ferris, Library Resources Manager; Gabriel Graves, Digital Assistant; Emer Quigley, Project Manager and Linda Devlin, Business Manager.

Submit your research to Lenus!

If you are an Irish researcher or have conducted research in an Irish institution or health organisation, you can add your **open access** published research to Lenus. Advice on open access publishing and publishers' policies is available on the 'Open Access Publishing Guide' and 'Publishers' policies' pages available on Lenus.

Where can you find more information or ideas for action?

Access the Data for Decision Making Resources webpage

Patient Safety Research Network

HRB and NQPSD to invest €1.25M to establish an Evidence-based QUality Improvement and Patient Safety (EQUIPS) research network

The EQUIPS network will bring together stakeholder groups, researchers, knowledge users and patient partners to advance Quality and Patient Safety (QPS) research and create a better understanding among patients and the public about the value and impact of QPS research. The multidisciplinary Network will be led by Professor Samuel Cromie, Trinity College Dublin (TCD), with Dr. Orla Healy, National Clinical Director of Quality and Patient Safety (NQPSD), HSE as the Lead Knowledge User on the award.

The project will run from now until November 2028. The HRB and HSE are funding the EQUIPS Network equally with an investment of €625,000 each.

"Translating our practical experience in quality and patient safety into evidence based, timely research outcomes is essential in a dynamic and evolving healthcare organisation.

At a time when we are focused on integrating services and changing how we structure and deliver healthcare, we have a unique opportunity to create a platform that enables us to capture tacit knowledge in essential fields like patient safety, human factors and public health. In doing so, there is significant potential for the EQUIPS Network to positively impact service delivery for people using healthcare."

Dr. Orla Healy, National Clinical Director, Quality and Patient Safety, HSE

"The EQUIPS Network builds on a 10-year collaboration between the HRB and HSE to advance quality and patient safety research through the Research Collaboration in Quality and Patient Safety (RCQPS). "Establishing the network aligns with many shared objectives that focus on improving outcomes for patients.

The network will provide a forum to debate and determine research priorities, support the development of a critical mass of research activity, and position Ireland to engage internationally to ensure we are at the forefront of best international practice when it comes to patient safety research and its application into practice."

Dr. Mairead O'Driscoll, Chief Executive, HRB

"EQUIPS is a very exciting opportunity to create a national collaboration to draw together expertise in key research clusters and build the capability and capacity for evidence-based improvements in quality and safety. The team includes 22 co-applicants and 28 collaborators with experience in QPS research spanning a range of disciplinary backgrounds including Health Systems, Implementation Science, Medical Education, psychology, Human Factors and Behavioural Science."

Professor Samuel Cromie, TCD

EQUIPS will have three strands:

- **The "Enable" strand** will put all the pieces in place to build a thriving research community: events, information sources, capacity and capability building.
- **The "Understanding and Informing" strand** will draw on this community, set priorities and strategies for QPS research, identify barriers and enablers and evaluate the network itself to apply the quality improvement cycle to it.
- **The "Focussing" strand** will consist of clusters to start working on priority QPS research topics, set the agenda for them, put consortia together and start pursuing funding. Two initial clusters will focus on System and Process Design and Implementation and Evaluation.

The network incorporates researchers and research groups/centres from seven universities in disciplines that include:

- Quality Improvement
- Patient Safety Science
- Implementation Science
- Health Psychology
- Human Factors
- Health Economics
- Safety Culture
- Systems Science
- Public Health

Where can I learn more?

Learn more about this developing project on our website

LEARN MORE

Upcoming events

Upcoming quality and patient safety training, events and networking opportunities

All resources are hyperlinked (where available)

International Forum for Quality and Safety in Healthcare

This year's theme is "Together to Regenerate Health and Care" and will focus on the key themes in health and care in Europe, while bringing in perspectives and knowledge from around the world.

Dates for your diary: 10th - 12th April 2024

QPS TalkTime series

Dates for your diary:

7th March 2024: QPS TalkTime Special Live from the International Collaborative
19th March 2024: Quality improvement in practice - Lead NCHD Programme
9th April 2024: Person Centred Lean Six Sigma Model in patient safety
23rd April 2024: Paediatric Sepsis
14th May 2024: Medication Safety
28th May 2024: Just Culture
11th June 2024: Clinical Audit

Open Disclosure webinars

Dates for your diary: 20th March, 17th April, 15th May, 12th June 2024

Tea-Time Catch Up for Q Community members in Ireland (and buddies)

Dates for your diary: 20th March, 15th May 2024

SUBSCRIBE

Join our mailing list to receive the latest on our newsletter, podcast series and webinars!

Share your thoughts, feedback or ideas...

Thank you for reading our fourth edition of Quality and Patient Safety Matters #AllThingsQuality. We would like this newsletter to be both helpful and inspiring.

We would love to hear from potential contributors. If you would like to include a piece in our June edition, please complete this short survey.

You can also tell us what you think about Quality and Patient Safety Matters or share topics you would like to read about by emailing juanita.guidera@hse.ie.

We look forward to hearing from you.

In spotlight

Upcoming training

National Centre for Clinical Audit Training

Fundamentals in Clinical Audit

- 09 April 2024
- 15 October 2024

Advanced Training Sessions

- 26 September 2024
- 28 November 2024

Register via HSELand
6 CPD/CEU points

Walk and Talk Improvement Podcast - Latest episodes

See page 17 for more information on our latest episodes. The series is available on Spotify, Amazon Music Prime, YouTube and Google Podcasts.

COMING SOON

Upcoming episodes

- Two episodes on Sepsis awareness
- In conversation with Professor Eva Doherty
- The role of the HSE Confidential Recipient: Grainne Cunningham-O'Brien

For your reading list

Last year we reported on the iSIMPATHY project. The evaluation report was launched recently and found that:

- 77% of interventions by HSE clinical pharmacists led to improved patient care
- 4% of interventions prevented major organ failure or serious adverse reaction
- saved over €1.2m due to fewer adverse drug reactions and admissions to hospital.

Find more details on our website or contact Ciara Kirke, Clinical Lead of the HSE's National Medication Safety Programme and HSE iSIMPATHY project lead via email on: safermeds@hse.ie.