An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

Edition 3 November 2023

Quality and Patient Safety MATTERS

#AllThingsQuality

Patient Partnership Bumper Edition

Your health, your voice

World Patient Safety Day 2023

How services across Ireland engage with patients

Latest on the Patient Safety Act and Open Disclosure Framework

ELEVATE THE PATIENT VOICE AND SAFETY THROUGH HEALTH LITERACY

A publication from the HSE National Quality and Patient Safety Directorate

A message from the editorial team

Welcome!

We are delighted to share with you our third edition of Quality and Patient Safety Matters #AllThingsQuality.

We thank our contributors who have shared the latest quality and patient safety news, World Patient Safety Day (WPSD) stories from teams around the country, educational content and upcoming training, events and networking opportunities in clinical audit.

This bumper edition focuses on “engaging patients for patient safety - elevating the voice of patients” which was the theme of this years World Patient Safety Day. You can read two insightful stories from patient partners Katie Verling and Alison Lynch who share their experiences of healthcare. You can also read about “Your Health, Your Voice” a campaign to improve health literacy using key questions which support patient safety by creating opportunities for increased understanding.

We also share the latest updates on a poster on intraoperative life threatening haemorrhage, the development of a National Quality and Patient Safety Competency Framework and New HSE National Patient Safety Alerts.

Our feature article on the Patient Safety Act 2023 and the National Open Disclosure Framework will give insight into the future legislative and policy framework.

We hope you both enjoy and are inspired by these and other stories as you continue to pursue your work to improve quality and patient safety. Please do contact us if you have any feedback for us 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. We look forward to hearing from you.

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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Our team

Editor

Juanita Guidera
Juanita.Guidera@hse.ie

Deputy Editor

Sheema Lughmani
Sheema.Lughmani@hse.ie

Follow us

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If you would like to share your ideas for content in Quality and Patient Safety Matters, Edition 04, January 2024, please complete the online survey.

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

As HSE staff, our work to improve patient safety is constant and it is underpinned by the Patient Safety Strategy. Each year on World Patient Safety Day (WPSD), we celebrate things we are doing well and through reflection and learning from others, identify things we can do better.

This year the World Health Organization focus was on elevating the voice of patients. A key challenged identified in discussions with Patients for Patient Safety Ireland was people's ability to access and understand health information. As many as one in three of us have difficulty with health literacy.

As a healthcare professional, one of the top things you can do to make a difference is to proactively ask people 'What would you like to know?'. You can also encourage people using our services to use "Your Health, Your Voice" which you can read about below. We also hope you enjoy reading about what happened across the country to celebrate this years WPSD.

In this edition, we bring you our regular articles and have two powerful patient stories to share. We also signpost the latest HSE Patient Safety Digest, a HSE National Patient Safety Alert from Patient Safety Together: Medical Device Regulation and CE Marking, a Patient Safety Supplement on Recognising surgical site infection at home and our new Patient Safety Together Spotlight Series.

Another key development in the past few weeks which will impact patient safety significantly in the coming years is the launch of the National Open Disclosure Framework. You can watch back our QPS TalkTime episode live from the National Patient Safety Office Conference for a key summary of the Framework and you can read about it and the implications of the Patient Safety Act 2023 for services in more detail in the newsletter.

Our aim in this edition of Quality and Patient Safety Matters is for you to have an opportunity to hear about quality and patient safety developments from staff, patient partners and the National Quality and Patient Safety Directorate Team. We hope that it is both relevant and useful.

Thank you to all who contributed to this publication and thank you for taking the time to read it.

Best wishes,

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

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 HSE operations, 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

Your Health, Your Voice

World Patient Safety Day: Engaging patients for patient safety
“Elevate the patient voice and safety through health literacy"

We can all struggle with healthcare information and it can have a significant impact on patient safety. We want people to be able to access and understand the information they need, when engaging with health services.

This year’s World Patient Safety Day and the Your Health, Your Voice approach designed to encourage people to ask questions.

“He could see it on their faces, they were all under pressure. It probably wasn’t that important anyway. Maybe he’d be able to ask the nurse on the way out…”

“Was bi-weekly, twice a week or every two weeks?”

“She’d spent 20 minutes on hold with another department - it was the third time she was late back to work after her tea break trying to find out who she needed to talk to about her mother’s care…”

For World Patient Safety Day (Sunday, 17th September 2023), a national collaborative project team with patient partners from Patients for Patient Safety Ireland (PfPSI), the National Patient Safety Office, Department of Health (DOH) and staff from across the HSE in acute, commuity and central services worked together to co-design a series of resources called 'Your Health, Your Voice'.

The purpose was to design and test these resources improve health literacy and patient safety for people using health services. Resources included: a leaflet, audio leaflet, animated clip, poster, video clips and website. (See next page for a list of resources).

Why is health literacy important?

It’s estimated that one in three adults (28.4%) will have difficulty accessing and understanding health-related information (European Health Literacy Survey 2019).

In Ireland, Literacy for Life, National Adult Literacy Agency (NALA) (2020) reported that:

- 47% of adults lack basic digital skills,
- 25% had difficulties using maths in everyday life,
- 18% of adults struggle with reading and understanding everyday text.

Health literacy impacts patient safety in many ways. It may be trying to understand how much medication to take and when, what to do before or following surgery, communicating with and understanding information from your healthcare provider or entitlements to services.

Every one of us can play a more active role in our own healthcare experience, by asking these questions when we are at a healthcare appointment:

Ask or answer

1. **What do I need to know now?**
2. **What do I need to do next?**
3. **What can I expect? How will this help me?**

The final question is key because understanding why something is important and the benefits influence how we act.

Bernard Gloster, HSE CEO, said:

"Our key message to you is: if you're not sure, please ask us. Most people we know have had an experience as a patient, or as an advocate for a child, a parent or sibling where they have struggled with healthcare information or instructions. This can impact everything from medication safety to the outcomes of care.

"We want patients and their families to get involved in the design and delivery of services. Your input and experience is valued. Meaningful conversations matter - in all our engagements, whether it's an appointment with your GP, a visit from the public health nurse or as a member of a working group."

Pictured above are members of Patients for Patient Safety Ireland and staff from the National Quality and Patient Safety Directorate celebrating World Patient Safety Day (from left to right): Tiberius Pereira, Angela Tysall, Kara Madden, Ellie Southgate, Katie Verling, Bernie O'Reilly, Anne McCabe Kelly, Dr. Maureen Flynn.

Kara Madden, Chair, Patients for Patient Safety Ireland, commented:

"As chairperson of Patient for Patient Safety Ireland, I am delighted that our group has been involved in planning for World Patient Safety Day 2023. Together with a team from the HSE and Department of Health we are co-producing and designing materials to support elevating the voice of patients.

My thanks to all involved in raising awareness of the active engagement of patients and families helping to improve patient safety at all levels. We know patients have a better experience if they are actively involved in their own care.This work is aligned to the Global Patient Safety Action Plan 2021-2030."

Deirdre Madden, Chair of the HSE Board's Safety and Quality Committee said:

"We want patients to be active partners in their own care, engaged in co-designing services, policy development, and partners in the governance structures delivering services.Through my work with the HSE Board Safety and Quality Committee, I've seen first-hand the impact of the patient voice at the table. I hope that people will acknowledge the importance of the patient voice and recognise that what patients have to say and what they would like to know is important for a quality and safe service."

Where can you find further information?

An information pack with materials, messages and new resources can be accessed online.

SCAN ME

Information pack resources

- **How can I play a more active role in my care?**
  - Your health, your voice animated clip
  - Your health, your voice leaflet
  - Your health, your voice, spoken version of the leaflet
  - Your health, your voice poster (signposting questions to improve health literacy)
- **"Introduction to World Patient Safety Day" videos**
- **Patient partnership stories - elevating the patient voice**
- **QPS TalkTime Webinar series**
  - QPS TalkTime Poster
  - Watch back the QPS TalkTime World Patient Safety Day special on 12th September 2023
  - Link to Patient Partnership QPSTalkTime playlist
- **Walk and Talk Improvement Podcast**
  - "Bearing witness, through life and death"
  - Link to listen back to previous Walk and Talk Improvement episodes
- **Quality and Patient Safety Matters #AllThingsQuality**
  - Articles from previous editions about patient partnership and involvement

What can you do to improve health literacy?

As a healthcare professional, one of the top things you can do is to ask people 'What would you like to know?'. You can also:

1. **Share the message Your Health, Your Voice widely through a leaflet or recording, an animated clip or poster and encourage people to ask us:**
   - **What do I need to know now?**
   - **What do I need to do next?**
   - **What can I expect? How will this help me?**
2. **Invite people to make a list of questions to bring with them to their appointments or ask someone to come with them**
3. **Signpost the HSE A-Z of health conditions**
4. **Ask 'What matters to you?'**
5. **Encourage people to keep a My Medicines List**
6. **Encourage people to get involved as a patient partner with local groups or through a the Patient Forum or Patients for Patients Safety Ireland**
7. **Signpost the HSE self-management supports for people living with long-term health conditions or peer support groups set up by advocacy groups.**

When everything changes...

Katie Verling, Patient Partner in conversation with Juanita Guidera, Editor

At the age of 44, Katie Verling had never been in hospital. When she experienced back pain for the first time, she ignored it – gardening took it's toll. When it persisted, she made her way to the GP, casually diagnosing herself. Several sleepless weeks later she went to the Emergency Department for pain so severe that morphine was not sufficient. Bloods were taken. What she thought was a short visit turned out to be life changing.

The blood tests identified leukaemia, and so began her experience of being a cancer patient. While she knew that leukaemia was a cancer of the blood, she did not know that there were four types and that she had an acute type that required immediate treatment.

Katie says that the doctor asking 'Do you know what it is?' was one of the most helpful questions on her journey.

Following a transfer to St. James' Hospital where they could manage her pain so that she could finally sleep, she remembers feeling safe and in good hands. Suddenly she was receiving treatment in an isolation unit, unable to work and away from home. The first doctors she met, in what would become her temporary home for several months, arrived on a Friday afternoon at four o'clock. The team welcomed her and advised that she would start treatment immediately. They explained what would happen and she was given a copy of the plan – the protocol for the next three to four months.

When asked what contributed to her positive experience, Katie said:

"The people on the team were open to questions and there was a willingness of the doctors to listen and explain any new symptoms. The nurses encouraged me to speak up and ask questions if I was concerned about anything. There was a trust, a sense of being heard and of being involved in my care."

Katie noted that while it was challenging it would have been more so without that support. She said that she never felt as loved and supported as when she was in hospital and perhaps did not realise how sick she was.

Katie noted that she had one negative experience with a person who was abrupt and who spoke of side effects of a necessary treatment with little regard for the individual who may experience them if things went wrong - her. While Katie is articulate, well read and able to hold her own, she spoke of the vulnerability she experienced during this meeting.

She also spoke of the trap of being an 'expert patient' and how it can result in delayed diagnosis, for example she remembered getting an itchy rash which she thought to be harmless but turned out to be shingles. At another stage she was feeling sick but, wanting to go to Italy for a wedding, she did not give staff time to explore what subsequently turned out to be a C. Difficile infection which resulted in a 6 week hospital stay.

Katie speaks about the experience of meeting others who were not familiar with the healthcare system and their fear of asking questions. In this instance, they ultimately found peer to peer support helpful, that is, they spoke with another person with a similar illness.

In healthcare settings it is difficult to know how much patients know, want to know, or how much information they can absorb. Neither healthcare professionals nor patients can make assumptions, because the circumstances for each individual are different and always changing. Our capacity to ask questions or retain information is affected by what we are told, and what we hear; what's happening in our lives, the languages we speak, our abilities, how clear the message is and so much more. The impact can be significant, from how we take medication, to how we clean a wound of an elderly relative, to after care following surgery, to the developmental milestones of our children, or the care required for our parents.

Pictured above is Katie Verling. Katie is a member of Patients for Patient Safety Ireland. In her former career in arts management she was an experienced policy maker, strategist, and collaborator.

Katie is now a member of Patients for Patient Safety Ireland (PfPSI). PfPSI is a WHO initiative aimed at improving patient safety in health care. The Irish PfPSI group's objective is to encourage health care providers to acknowledge patients and their families as an untapped resource for information and recognise the patient experience as a learning tool. The group, including Katie were central to the development of the Your Health, Your Voice campaign.

Where can you find further information?

To find out more about PfPSI, access patientsforpatientsafety.ie

If you would like to encourage people using health services to ask questions to aid understanding and access - you can start with the questions below. You can find out more on the National Quality and Patient Safety Directorate website.

1. What do I need to know now?
2. What do I need to do next?
3. What can I expect? How will this help me?

Navigating the difficult journey of fatal fetal diagnoses:

Alison's story

Alison Lynch in conversation with Sheema Lughmani, Deputy Editor

"When you're in that situation, you're grasping at straws of hope."

When faced with life-altering news of a fatal fetal diagnosis, the journey that follows is often filled with complex decisions, emotional turmoil and profound challenges.

Alison Lynch is the chair of Leanbh Mo Chroi (LMC) Bereavement Support, a charity dedicated to aiding women and parents receiving such diagnoses. In June 2023, she shared her deeply personal experience as part of the patient stories shared with the HSE Board's Safety and Quality Committee.

At the age of 41, Alison embarked on the path of motherhood using a sperm donor and fertility clinic services. While initially a textbook pregnancy, a routine scan at 25 weeks took an unexpected turn when the sonographer mentioned a cleft lip and, more alarmingly, fluid around the baby's brain. The news shook Alison, "What do you mean fluid on the brain? Where did that come from?"

Following this very worrying news, Alison met with her consultant. The consultant's words hung heavily in the room as she explained the severity of the baby's condition, from brain abnormalities to kidney issues. The next five weeks were "torturous" for Alison as she underwent many tests that ultimately resulted with no diagnosis.

"Unfortunately women in my situation face agonising waits for tests and scans while trying to find out what's wrong with their babies. As time is of the essence in these situations, even waiting a week for tests is torturous let alone the much longer waits that many women face."

Given the anticipated suffering her baby would endure, Alison made the heart-wrenching decision to terminate the pregnancy. However, without a working diagnosis, Irish legislation at the time meant Alison had to journey to the UK to terminate the pregnancy. It was at the consultation (in Liverpool) that the first working theory was presented: Joubert syndrome, a severe and life-limiting condition. She speaks highly of the compassion and care received from the medical staff, helping her cope with the overwhelming situation.

After the procedure, Alison found herself navigating a challenging path of grief and recovery.

The genetic report, once completed, unfortunately didn't offer much, noting "five variants of unknown significance." Alison was advised to use a different donor next time, which she did.

In her second pregnancy, Alison was monitored very carefully, but "any pregnancy after loss, there's quite a bit of anxiety that's attached." She found herself focusing less on the screen and more on the consultant's face, searching for any sign of concern.

The consultant, when scanning the head, asked with a puzzled expression, "how many weeks are you?" Alison's heart sank. She found herself back in a familiar holding period, waiting for further tests and analysis. It was a difficult time, as she had to wait until her baby was 22-23 weeks for a proper MRI of the brain.

In the midst of this waiting period, a geneticist looked at her first baby's post mortem examination results and history. Tests were conducted on Alison and her family members, and the results led to a crucial discovery. There was a previously unknown family history of the OFD1 gene (oro-facial digital 1), with both herself and her mother as carriers. This information was critical in recategorizing the previous "variant of unknown significance" to "likely pathogenic" (which means there was a medical cause). The discovery ultimately led to a more informed decision in her second pregnancy. The MRI results confirmed severe brain abnormalities, yet this time, Alison chose to continue the pregnancy, knowing her baby would not suffer, and she could have a few precious hours to hold him.

Alison's experience serves as a poignant reminder of the deeply personal and complex nature of fatal fetal diagnoses.

Her story sheds light on the challenges faced by parents who must navigate this difficult terrain, and the crucial need for supportive and compassionate care throughout the journey. "My care overall was very good, but in my work with LMC, I find, a lot of the times, that's not always the case. If you're at a hospital that's experienced in these things, you receive very good care. But if not, the care you get is not very good at all."

Alison's hope is that with improved understanding and support, this process can become less of a "hospital lottery" with care standardised across the board, ensuring that every family facing such diagnoses receives the care and guidance they need during these uncertain times.

Learn more about the HSE Standards for Bereavement Care following Pregnancy Loss and Perinatal Death here.

Watch the full video on on our YouTube channel.

World Patient Safety Day 2023

How services across Ireland marked this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

UL Hospital Group mark World Patient Safety Day

Paula Cussen Murphy, Director of Quality, Risk and Patient Safety shares the week's activities

The UL Hospitals group celebrated World Patient Safety Day over a full week of events on all sites.

This included awareness stands in:

- University Hospital Limerick
- Nenagh Hospital
- Ennis Hospital
- Croom Orthopaedic Hospital
- St. Johns Hospital.

As well as the information stands, we also held events for staff to help raise awareness around patient safety including, a patient safety learning event and a cardiac arrest simulation.

'It's Safer to Ask' Campaign

We set up 'pop up' information stands on each site throughout the week. Members of the QPS department supported each stand as well as volunteers from our patient's council. Our main aim for these stands was to encourage engagement with patients attending clinics and out patient's department appointments. We supplied these patients with helpful leaflets titled 'It's Safer to Ask'.

Picture 1

'Patients and family members who are more informed and involved in their healthcare often experience safer and better care and have improved quality of life afterwards.'

Patient Safety Learning Event

On Wednesday, 20th September we held a full day learning event for all disciplines on the patient safety priorities outlined in the HSE's Patient Safety Strategy 2019-2024.

Attendees commented on what they enjoyed about the day:

> **"It updated my knowledge as well as improved my confidence to take care of patients in a safe way as I am in a new area of work."**

- **Picture 1: (left to right) Beth Farren, Patient Safety Strategy Manager Mike Conlon, Head of Operational Services.**
- **Picture 2: Trauma Orthopaedic ward staff.**
- **Picture 3: (left to right) Orla Hammersley, Quality Improvement Development Manager, Kathleen Keane, Patient Advocacy Liason Officer, Polly Ryan, Patient Advocacy Liason Volunteer,Beth Farren, Patient Safety Strategy Manager.**

Cardiac Arrest Simulation- Trauma Ward

To close out World Patient Safety Week, a Cardiac Arrest Simulation event was held, led by one of the Anaesthetic Consultants, a theatre nurse and the Resuscitation Officers. This simulation included the management of an orthopaedic spinal patient during a cardiac arrest situation. A debrief, led by a Consultant Anaesthetist highlighted the fantastic learning gained. We hope to run more of these simulations in the future to support staff and identify patient safety issues to improve the quality of care we give to our patients.

Picture 2

Picture 3

Throughout the week, we received excellent engagement from all hospital sites, staff and patients. We hope that by creating patient safety awareness through conversation and education we can empower patients and staff to speak up for patient safety.

We asked patients directly how we as an organisation can ensure that they have all the information that they need.

Here's what they had to say:

"An APP would be helpful with personal log in details that would show future appointment times and dates. There could be information also on the clinics we are attending and what to expect."

"Follow up email or call with instructions and recommendations from the appointment."

"Short summary at the end of the consultation for the patient so I can take down bullet points."

"More information leaflets on aftercare and my condition."

We asked staff how the organisation could support them to help keep patients safe.

The top 3 patient safety priorities identified were:

1. Reducing medication related harm.
2. Recognition and response to the deteriorating patient.
3. Improving safety of transitions of care including clinical handover.

World Patient Safety Day 2023

How services across Ireland marked this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

Maura Grogan, Quality Manager shares WPSD activities held at Tipperary University Hospital

Tipperary University Hospital hosted a wide range of patient safety awareness events, including:

- Positive patient identification
- Risk of falls
- Venous thromboembolism (VTE) awareness
- Medication safety "Know, Check, Ask" leaflets
- Pressure ulcers
- Your health, your voice
- Sepsis
- Safe site surgery
- Patient Safety Strategy

Members of our Inclusion Working Group and Patient Service Users Representative Forum were also in attendance to support the hospital.

The Quality Team at Tipperary University Hospital (TippUH) actively engage patients for patient safety. One of our most valuable initiatives to engage with patients is through the Patient Representative Service User Forum. This forum meets quarterly and allows Tipperary University Hospital to actively seek input from patients or their representatives in the planning, design and delivery of services.

Tipp UH have also established an Inclusion Working Group, which encourages the involvement from all diverse communities such as LGBT+, Traveller, Roma, Refugees and International Protection applicants. In addition to quarterly meetings with the Inclusion Working Group, the team at TUH meet these groups in the community to provide training and awareness days. Tipperary University Hospital are grateful for the ongoing engagement, support and commitment received from both groups.

Each year, TUH invite a patient to speak at their Annual Quality Day to share their experience and tell their story. In 2023, TippUH took this a step further and invited a patient representative to Chair the afternoon session of the Quality Day. The input from and ongoing engagement with patients helps to create a learning culture and promotes improvements in patient safety in Tipperary University Hospital.

- **Pictured below left, staff from Tipperary University Hospital with Jo Lonergan, Patient Representative; Maura Grogan, Quality Manager, Tipperary University Hospital and Elaine Egan, Patient Safety Strategy Coordinator, SSWHG.**
- **Pictured below right: Sepsis team: Mr. Waseem Swati, Consultant Surgeon, Anna Butler, Sepsis Project Lead, CNM2 and Mr Ilyas Khan, Consultant Paediatrician**

Sheena Bolger, Patient Safety Manager shares how the Coombe Hospital engaged with patients and staff

Light up!

We started this year with our hospital being illuminated in orange lights to mark World Patient Safety Day.

Speak Up - Communicate

There were fantastic information sessions and discussions held on patient safety topics in the hospital facilitated by Sheena Bolger, Patient Safety Manager; Terry Tan, Consultant Anaesthesiologist and Peter Duddy, Medication Safety Pharmacist on topics such as: Just Culture, National Healthcare Communication and Medication Safety. There was great attendance across all grades of hospital staff who listened and most importantly contributed.

Speak Up - Promotion

The Quality Risk Patient Safety team ran a promotional day for all women attending our maternity and gynecology services as well as the hospital staff, promoting the aspect of 'speaking up' and encouraging interaction with their healthcare providers with the use of the health literacy information leaflets;

- What is my main concern?
- What do I need to do next?
- Why is this important?

We had a promotional stand in the main foyer of the hospital encouraging patients and staff to speak up.

Speak Up - Psychological Safety

Dr. Sabrina Coyle, Senior Clinical Psychologist held a facilitated panel discussion on various aspects of Psychological Safety. There was a pre-nominated panel identified to get the conversation going and discuss their experiences of psychological safety (personally and professionally) in the hospital environment. The panel consisted of various grades of medical and nursing/midwifery staff, and a parent of two Neonatal Intensive Care Unit (NICU) graduates.

The discussion was interactive, insightful, open and honest about individual experiences of speaking up and acting on various concerns as staff members, patients, parents and close family members.

> **"This led to a very engaging conversation amongst all in attendance on the absolute vital importance of feeling safe enough to speak up if something is not right, and even more so, the importance of being heard and respected for doing so.**
>
> **In the essence of patient safety, it was identified that whilst psychological safety and speaking up is crucial as a healthcare professional, it is imperative as we are all likely to become patients one day."**

World Patient Safety Day 17 September 2023

World Patient Safety Day 2023

How services across Ireland marked this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

Tallaght University Hospital (TUH) mark WPSD through open disclosure and ePOE

Lisa Maher shares updates from TUH

In celebration of World Patient Safety Day (WPSD), our team participated in an information stand to support open disclosure training, reinforcing our commitment to transparency and safety. They also engaged staff in a patient safety quiz, complete with raffle prizes, to foster a culture of patient-centred care.

TUH are also implementing Electronic Point of Entry (ePOE) incident reporting through the National Incident Management System (NIMS), live on 14th November, 2023. This transition represents a significant leap in enhancing patient safety, optimising incident management and eliminating the administrative burden associated with paper-based reporting. The NIMS system promises to revolutionise our processes. It seeks to ensure efficiency and accuracy while reducing paperwork, ultimately allowing us to focus more on patient care.

Additionally, our Quality, Safety and Risk Management (QSRM) department is actively engaged in a series of Quality Improvement initiatives aimed at continuous improvement. To expedite falls and pressure ulcer root cause analysis, we have introduced electronic versions of these forms and templates on our intranet system. This innovative approach not only accelerates the completion process but also facilitates prompt follow-ups, system-wide learning, and improved KPIs. Furthermore, we are implementing an electronic version of the Serious Incident Management Team (SIMT) recommendation tracker, enhancing quality of care and reinforcing quality assurance post-incident review.

Frances Ni Fhlannchadha, Risk and Incident Management Lead; Rory Dignam, Patient Safety Manager; Anne Byrne, Risk and Incident Manager; Catherine Wall, Director of Quality, Safety Risk Management and Lorraine Schwanberg, Assistant National Director Incident Management.

Meliosa Moran, ICT Project Manager - ePOE.

Our Lady of Lourdes (OLOL) and Connolly Hospital mark WPSD

Orla Kenny, Patient Engagement Manager, RCSI shares how OLOL and Connolly Hospital utilised social media to engage with patients

Connolly Hospital celebrated WPSD by raising awareness with staff on the importance of using plain English when communicating with patients. The aim was for people to understand information the first time they hear or read it and in doing so, encourage them to be an active participant in their own care.

The 'My medicine list' was promoted with patients to demonstrate to them the importance of being involved in their own care and knowing their own medications when they attend hospital to promote medication safety during transitions of care.

World Patient Safety Day 2023

How services across Ireland marked this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

Patient Advocacy Service

In conversation with Roisin McKeon, Communications Officer

How did you promote World Patient Safety Day this year?

The Patient Advocacy Service (PAS) was delighted to promote World Patient Safety Day, 2023 through a social media campaign and a series of talks with services. We shared key Patient Safety messages from the World Health Organisation and HSE.

Team Lead, Mary Jacob, presented to the Ireland East Hospital Group as part of their Lunchtime Talk Series. Mary provided information on our service, supports we offer and highlighted case examples of how, in the past year, we have empowered people to have their voice heard. The presentation opened a day of events for the Group and received positive feedback.

Members of our service also spent a day with the Midlands Hospital, Portlaoise to mark World Patient Safety Day. Team Lead, Padraig Ruane and Advocacy Officer, Melanie O'Carroll presented to staff and met with members of the public to talk about our service and the importance of advocacy in supporting patients to have their voice heard.

Did you know the Patient Advocacy Service is commissioned by the National Patient Safety Office at the Department of Health?

PAS is provided by the National Advocacy Service for People with Disabilities.

Melanie O'Carroll, Advocacy Officer, PAS and Padraig Ruane, Team Lead, PAS at the Midlands Regional Hospital, Portlaoise.

Why did the Patient Advocacy Service get involved?

This year's theme for World Patient Safety Day 2023, "Engaging patients for Patient Safety" resonated with us. Our work with patients, nursing home residents and families highlights the impact that positive patient engagement (through the complaints and incidents processes) can have. Listening to the person's story, what they hope to achieve and supporting them to have their voice heard and sharing their lived experience improves the patient experience.

How does the Patient Advocacy Service promote patient safety?

By supporting understanding of policies, such as Your Service, Your Say (YSYS), Open Disclosure and the Incident Management Framework, we empower meaningful, person centred engagement with services to improve openness and transparency. Since our service began in 2019, we have supported over 3,500 people.

Our work demonstrates that listening to patients and giving them an opportunity to share their lived experiences can enhance communication, trust and learning, and improve Patient Safety for all.

What is the Patient Advocacy Service and where can I find out more?

The Patient Advocacy Service is independent, free and confidential. It supports people to make a complaint about the care they have experienced in a Public Acute Hospital or Nursing Home. It can also support people in the aftermath of a Patient Safety Incident.

Telephone: 0818293003

Partnership in the Community (Falls Prevention)

Colm Harty, Patient and Service User Engagement Officer, Community Healthcare East in conversation with Juanita Guidera, Editor.

At the recent Public and Patient Partnership Conference I had the privilege of presenting a piece of partnership work that was undertaken by both patients at high risk of falls and HSE staff members. I was delighted to be part of such a project which was co-funded between Older Persons Services and Primary Care Services in Community Healthcare East and was aimed at reducing the risk of falls and improving education around falls prevention.

The cornerstone of this project was to partner with patients and gain knowledge from the lived experience of people who had experienced falls and who were of high risk for future falls. Effective co-production was paramount to this project and using some tools provided in the HSE Better Together Roadmap this process was formalised, structured and co-produced.

How did you do it?

Initially, we conducted a mapping survey sent out to 120 people identified as being at high risk of falls. As part of this survey, there was an option to become involved in a focus group where the results of the survey would be discussed and agreed actions could be decided upon. This was highly informative as having the lived experience of individuals shared amongst specialty healthcare professionals offered a different perspective. It highlighted how the value of the person's lived experience carried weight in relation to the healthcare actions arising.

What were your key takeaways?

From my own perspective, one main takeaway was that providing a seat at the table for lived experience when it came to service improvement resulted in strong relationships between Service Users and Healthcare professionals. Also, the feeling of ownership for individuals over their service meant that they were more confident to report falls and in liaising with the service around providing up to date educational material around falls prevention.

Key actions were brought forward to the project team following the focus group with some changes to the current falls booklet being suggested. One such change suggested was to include information about personal alarms which has been actioned and will be included in the updated version of the falls booklet.

A key takeaway for me was how comfortable people with similar experiences were when we ran the group. One of the key points that arose was underreporting of falls which the group agreed was down to shame and stigma. However, in this group of people who had experienced falls or understood the health implications of falls, there was comfort in speaking about it and sharing their experience.

Some quotes from the group that stand out to me around this were:

"I feel no shame discussing my falls in this group."

"Sharing of real life stories with people with similar experiences is comforting."

"I enjoyed the conversations, telling my story."

What are your next steps?

With the relationships built through the contact with all of the appropriate individuals involved, the link is now built to co-produce service improvements or changes in the future. The local foundations have been built to support working alongside service users in partnership around the design, delivery and evaluation of this service going forward.

Where can you find more information?

To find out more about this work email: Colm.Harty@hse.ie

Watch this space QUICKPatientSafety App

What's happening?

The National Quality and Patient Safety Directorate is currently co-designing and testing an easily accessible mobile app called QUICKPatientSafety.

Who is it for?

Healthcare professionals interested in using QI to address priority patient safety areas.

What's it about?

The app use an evidence-based care bundle approach to address patient safety risk areas, and demonstrate quality improvement methods to inspire healthcare professionals to use QI in implementing the bundles. The first patient safety area addressed is reducing harm from falls, and the next one will be reducing and managing pressure ulcers

When it it coming?

The app is due to be released in 2024.
Contact QPS.Improvement@hse.ie to learn more.

World Patient Safety Day 2023

Patient Partnership in focus

Patients take central role at the first National Patient Partnerships Conference

On Thursday, 12th October 2023, the first annual HSE National Conference on Patient and Public Partnership was held in the Convention Centre. It was attended by patient advocates, healthcare professionals, policymakers, and stakeholders.

The conference was hed as there is a growing recognition of the invaluable role that patients and service users play in shaping health care delivery, policy development and organisational governance. A lot of work is underway to increase partnership with patients but much remains to be done.

The conference was organised by the HSE and patient partnership groups including the HSE's National Patient and Service User Forum, the Irish Platform for Patient Organisations, Science and Industry (IPPOSI) and Patients for Patient Safety Ireland. UK based patient advocate Carol Munt gave the keynote address.

Pictured above is a visual representation of "The People's Health Service" designed by Christine Fenton, patient and patient partner who interviewed Bernard Gloster during the conference. The different colours represent the roles of individuals at the conference.

Anne Lawlor, Chair of the HSE's Patient Forum and long-time active patient advocate and founder of 22q11 charity Ireland said:

"I know from my own personal experience that positive changes can happen when you get the chance to work in real partnership with HSE staff and teams. It can be a 'win win' for everybody but especially for patients, families and communities. When I joined the HSE Patient Forum in 2015 it felt like the patient's voice was very much a 'tick box' exercise for the HSE. It feels quite different now.

"To me patient partnership is incredibly important. I believe there is a real commitment within the HSE now to working in partnership with patients. There are still many frustrations but I do think that things are improving. I was recently the patient representative on the interview panel to appoint a new HSE Assistant National Director for Patient Service User Engagement (PSUE). It is important to me that patient advocates sit on HSE interview panels for these roles. If the patient voice isn't represented at every level within health services, far too many assumptions are made. There's a way to go but I'm confident progress is being made."

Bernard Gloster, HSE CEO, said:

"We recognise that partnership initiatives are currently taking place across the Irish health sector, but in different ways and with varying degrees of success. We know that common approaches are needed to ensure shared expectations are realised and agreed goals are met.

"Partnership with patients and service users (and their families, carers, and supporters) will be a cornerstone of how we work across our health system and broader health sector. This requires a cultural shift, but this move is in line with international best practices and offers numerous opportunities. The HSE is committed to partnering with patients to ensure more and more patients will influence decisions on the design, delivery and evaluation of health services."

World Patient Safety Day 17 September 2023

World Patient Safety Day 2023

An example of service design to meet patient needs

Designing services to meet patients needs

Denise Conway, Community Intervention Team, Outpatient Parenteral Antimicrobial Therapy Clinical Nurse Specialist in conversation with Juanita Guidera, Editor

Could you tell us about the work of the Community Intervention Team in Tipperary University Hospital?

The Community Intervention Team (CIT) is a nurse led service. We provide support visits, education and training, advanced interventions and the administration of out-patients parenteral antimicrobial therapy (OPAT) in the community. Our aim is to facilitate early discharge for suitable candidates from the acute setting.

This service promotes self-management of the patient's condition and the ongoing delivery of required intravenous (IV) therapy in their own home or other health care facilities. It helps prevent hospital admission, avoid hospital attendance and saves hospital bed days.

What is the benefit of this service for patients? What are patients saying?

All patient feedback to date has been very positive and people are grateful to receive treatment at home with their families, rather than in hospital. They also tell us that they would recommend the service and choose it again over hospital admission for IV therapy if it was required again.

One lady was treated in another healthcare facility to afford her the availability of extensive physiotherapy which was required as her infection had caused limited mobility. Had OPAT not been an option she would have remained in a general hospital ward. Due to her existing condition, an associated risk of long hospital admission may have included becoming further deconditioned due to lack of mobility along with the added risk of contracting hospital acquired infections. In this case, the patient received four weeks of OPAT therapy combined with physiotherapy and walked home a month later. She stated that the treatment and service she received from all involved was "absolutely wonderful".

Another service user was Fr. Jim Egan. He shares his experience here.

Fr. James Egan shares his experience of OPAT

"I was introduced to OPAT in August of this year, 2023. The HSE have successfully treated me for heart disease from 1968 to now, and I'm eternally grateful to the service and the many great people who maintained the health of the nation through all those years. However the OPAT service which cared for me recently is the 'Jewel in the Crown'.

The OPAT 'Clonmel Team' are so professional, efficient and kind to its patients, that my hope and prayer is that this service will continue to grow and bring hope and solace into the lives of patients who often feel vulnerable and alone in times of illness.

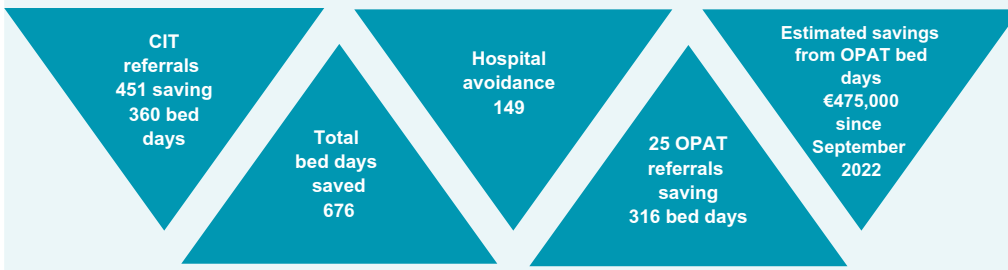
Apart from its obvious medical services, the strength of OPAT is that they can deliver this service in the patient's own home, thus freeing up badly needed hospital beds in our public hospitals. I found the OPAT team most friendly, efficient and enabled personal support to their patients.

As a fortunate and happy recipient of OPAT and the services they offer I can honestly say my recovery was expedited and carefully monitored from the comfort of my own home. The transition from hospital to my home and finally to my local public health nurse was very successful.

OPAT is a growing service and deserves every support, it enhances our health service, makes economic sense but above all is an invaluable service to all patients needing this hospital treatment. The nurses are kind, professional and efficient and deserve all our support. Rehabilitating at home under OPAT care enhances the patient's physical and mental health, frees up our hospital beds for acute medical care and helps alleviate the financial pressure experienced by the HSE."

Pictured above are Denise Conway, CIT/OPAT Clinical Nurse Specialist with Fr. James Egan, a service user.

Statistics to date since the CIT/OPAT post commenced: 1st August 2022 to 1st November 2023



World Patient Safety Day 2023

An example of service design to meet patient needs (continued)

John Egan, a patient was able to avoid 25 days in hospital while using the OPAT service. At home he was able to slowly return to his normal level of independence and was able to walk his lane which was important to him. When asked about the service he said:

Pictured left are Denise Conway, CIT/OPAT Clinical Nurse Specialist with John Egan

> **"I received the OPAT therapy at home with my family and it meant I could be at home for Christmas. The service was A1 and the nurses were lovely. I looked forward to meeting the team on my weekly clinic reviews."**

In further discussion with Denise, she shared practical things she did when establishing the OPAT service, her experience and learning which was fundamental to the success of the programme to date. We hope you find the summary below useful in your own work.

Identifying areas of good practice and learning from other areas

- Researched the CIT / OPAT services in other areas online.
- Worked alongside the CIT / OPAT nurses in numerous other hospitals, (CUH, MUH, Tullamore, and Wexford) in order to gain insight from their experiences.
- Introduced myself and brainstormed with other CIT/OPAT nurses in Dublin and Kerry and North Tipp and Letterkenny.

Gathering data to inform service design and continually improve the service

- Speaking with patients and staff about what's working and not working as the service developed and making changes as needed.
- Developed patient surveys to receive feedback and continue to improve the service.

Building relationships and good communication

- Meet regularly with people to develop good relationships. Ongoing communication both formally and informally helps ensure a safe practice and promote the service.
- Developing good communication.
- Being seen, approachable and easily contactable.

Providing education to all staff members

- Facilitating training and education sessions for CIT nurses on current up-to-date practices, for example, Percutaneous Endoscopic Gastrostomy (PEG) care, Airvo, BiPap and Diabetes by utilising the experts in those areas in TippUH.

Raise awareness of the role, referral processes and benefits

- Presented at the Annual Quality Day in Tipp UH
  - to raise awareness of my role,
  - increase awareness of the service and referral process,
  - highlight the benefit of the service through case studies and statistics on the impact of the work.

Continuous development of personal skills

- Attending annual OPAT conferences to keep updated of any developments within the service.
- Undertaking training in Mid Line Insertion which is required for OPAT administration. (It is a less invasive procedure for the patient and prevents the time, theatre space and need for anaesthetic involvement for Peripherally Inserted Central Catheter (PICC Line*) insertion, all of which contributes to delays in discharge. This has made the pathway much swifter.
- When I was appointed to the position of CIT/OPAT CNS, I had the benefit of being part team who established the CIT Team in South Tipperary seven years ago and I had 28 years of Emergency Department experience. However, I was not as confident or familiar with the administrative aspects required to ensure a safe, quality and efficient service at the initial setting up, for example, establishing policies and guidelines, auditing, spreadsheets, on line referrals, establishing pathways, developing information leaflets, appointment cards, or arranging outpatient departments. This came with time and are well established now.

> **"For others like me, I would highly recommend using the resources available from the Quality Department. The Quality Manager here in TippUH has been a huge help in giving advice, assistance with key performance indicators, patient satisfaction tools, surveys and articles."**

Where can you find more information?

To find out more about this work email: Denise.Conway@hse.ie

Glossary of terms

1. Out-patients parenteral antimicrobial therapy (OPAT) is a service to allow patients who are medically stable to safely receive their intravenous (IV) antibiotics at home if they have been assessed as suitable.
2. Percutaneous Endoscopic Gastrostomy (PEG) is a type of feeding tube which is inserted through the skin of the abdomen into the stomach.
3. Airvo is for the treatment of patients who would benefit from receiving high flow warmed and humidified respiratory gases.
4. BiPap is a type of ventilator - a device that helps with breathing.
5. A Peripherally Inserted Central Catheter (PICC) line is a thin, soft, long catheter (tube) that is inserted into a vein in your arm, leg or neck. It is used for long-term intravenous (IV) antibiotics, nutrition or medications, and for blood draws.

World Patient Safety Day 2023

Elevating the patient voice through peer support

Safety in numbers - peer support groups make a difference

Mary-Rose Cunningham, Self Management Support Coordinator for Long-term Health Conditions; Mairéad Holland, Patient and Service User Engagement Officer and Denise Croke, Health Promotion and Improvement Officer

COPD Support Ireland and the Health and Wellbeing Team / Enhanced Community Care Team in Dublin South, Kildare and West Wicklow, Community Healthcare (DSKWW) recognised the need for additional supports for people living with Chronic Obstructive Pulmonary Disease (COPD) in Co. Kildare who had completed the pulmonary rehabilitation programmes in the local hospitals /health centres.

There was recognition that following on from this structured and safe exercise programme, participants were left in a vacuum. While the exercises themselves were safe to complete at home, and this had been encouraged throughout the pulmonary rehabilitation programmes, levels of adherence were poor without the designated structure. There was also a social void that was left behind, with participants' mental health benefitting from the regular social interaction and peer support and understanding.

The self-management support co-ordinator for the region, Mary Rose Cunningham set up a working group in early 2023 to explore potential strategies to address these needs. This culminated in the launch of two new peer COPD Support Groups in Co. Kildare in Newbridge (June) and Athy (July).

Who participates in the local support group and why?

The local support groups bring together those living with COPD for peer support and socialisation as well as weekly exercise. Being a member of these groups is an essential part of self-managing their long term health condition physically, mentally and socially.

How did you ensure to have the patient at the centre of vision when launching the new COPD support group?

Including patient partners who could share the lived experience of being part of a support group was essential. Following advice from Mairead Holland, Patient and Service User Engagement Officer we invited two members from groups already established in Tallaght and Ballyfermot. They were really powerful in their testimony on how being part of the group had improved their quality of life and been a great support to them. The message was conveyed loudly and clearly that the ownership of the group rested with the participants and that while support was available to them from all participating stakeholders, ultimately the direction of the group for example, social outings or what information topics they would find most useful, would be directed by the group.

What is Chronic Obstructive Pulmonary Disease?

Chronic Obstructive Pulmonary Disease (COPD) arises where there is airflow obstruction in the airways of the lungs leading to shortness of breath.

Smoking accounts for the majority of cases. It can also arise from being in an environment where there is exposure to smoke, dust or fumes, or where a person is living with an existing condition such as chronic asthma, or has a family history of certain lung related illnesses.

It is estimated that 380,000 people are living with COPD in Ireland yet only 110,000 are diagnosed.

At least 1500 patients die each year of COPD.

Over 15,000 patients are admitted to hospital with COPD yearly.

It is particularly prevalent in the more vulnerable in society including people from areas with high social deprivation.

The peer education aspect from a lived experience perspective was and remains pivotal in overcoming any potential barriers around health literacy, while professional support is also on hand.

Another important consideration, as previously referenced, is the social aspect. Many members may be restricted in relation to mobilisation and activity and find it hard to meet with people who understand these limitations. The peer support group may provide a forum for meeting other people, a reason to leave the house or the confidence to see how they can live more actively.

The group meets in the local family resource centres. This is a conscious decision to ensure that there is a community rather than healthcare focus. The cup of tea and chat are as much part of the support for people as the more formal elements of the programme. It also builds relationships between the service user and the community centre which could potentially lead to wider engagement in other activities, once more reducing isolation.

Pictured below are members of the panel at the launch of the Athy COPD Peer Support Group

World Patient Safety Day 2023

Elevating the patient voice through peer support (continued)

Pictured above are photos of the launch of the Newbridge COPD Peer Support Group

What is a COPD Peer Support Group and what role do the play in self-management?

COPD Support Ireland (COPDSI) is a national organisation for people living with COPD. It delivers self-management advice, information, education, and community-based COPD tailored exercise classes in a peer support setting to people living with COPD. It does so through a national network of 44 local support and exercise groups. It is planned to establish support and exercise groups in the 96 community health networks over the next 3 years.

A COPDSI Stakeholder Survey of people living with COPD in 2022 listed the top 5 benefits from attending COPDSI groups as:

- I am more physically active because of the exercise classes
- My mental wellness is improved
- I enjoy socialising and feel more confident in socialising with my COPD
- I have learned a lot about my COPD from other members
- I have learned a lot about my COPD from the education sessions.

This suggests that COPDSI support and exercise groups improve the self-efficacy of people with COPD in self-managing their disease. It is hoped that these benefits will also result in reduced hospitalisation rates for COPD.

What are benefits of patients living with COPD to join a local group?

For Joan Johnston, General Manager of COPD Support Ireland, physical activity is a vital part of maintaining health for people with COPD:

> **"It is well-documented that maintaining or increasing physical activity levels in day-to-day life can improve the symptoms of COPD. In fact, apart from quitting smoking, it is the single most important thing that we can do.**
>
> **The COPD Support Ireland model of Self-Management support and exercise, delivered in a peer support setting is based in evidence, can reduce acute care events and improve self-efficacy in the COPD patient population. Continued HSE support of COPDSI in growing the number of groups across the country will further help reduce the age-sex standardised hospitalisation rate of the COPD population in Ireland which remains one of the highest in the OECD at 238 admissions per 100,000 population compared to the OECD average of 151.3 admissions (NHQRS, 2022)."**

What do you think contributed to the success of the launch?

The Self-management support coordinator identified that clear patient information would encourage patients with COPD in the area to join the support group after completing pulmonary rehabilitation.

We chose a questions and answers panel discussion format. This provided a great insight into joining the group. The clinical specialist physiotherapist provided the clinical evidence on the benefits of a COPD support group for self-managing the condition. The patient service user engagement lead ensured the patients voice was advocated for at each step.

Hearing the testimonials of the impact on the quality of life of other group members really inspired the people at the launch to come back and be part of their own group.

How does COPD support Ireland and the HSE ensure patients are kept up to date in the long term?

The group will have education sessions and short talks from healthcare professionals on aspects of care and living with COPD, for example use of inhalers, accessing local resources and signposting to other support networks. Importantly they can let us know what they want to hear about so that all information is focused on their own identified needs.

There is also the continued relationship with HSE healthcare professionals - respiratory clinical nurse specialists and physiotherapists, COPD support Ireland and information, and a dedicated trainer for the programme.

How will you know that the group is a success?

We (the self-management support co-ordinator, the patient and service user engagement officer & COPD Support Ireland) will regularly meet with the group and ask for their feedback on what is working well and what needs to be improved. This ensures the group will remain at all times focused on the needs of those attending. This is very much a peer support group supported by healthcare providers and remaining true to the principal of "nothing about me without me."

Where can you find more information?

To find out more about this work email Denise.Croke@hse.ie; MaryRose.Cunningham@hse.ie and Mairead.Holland1@hse.ie

World Patient Safety Day 2023

How services across Ireland used social media to mark this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

World Patient Safety Day 2023

How services across Ireland used social media to mark this year's WPSD theme of "Engaging patients for patient safety: elevating the voice of patients."

Carol Foley @CarolFo79217860 · Sep 22

UMHL marking world patient safety day today #WPSD23 meeting service users to educate re asking questions about their care and promoting medication safety @ronan_eileen @BethFarren5 @ULHospitals @CussenPaula

Doreen Powell @dpchb1 · Sep 15

Taking account of the literacy and numeracy needs of Patients by using plain English is one way to help them understand information the first time they hear or read it. Promoting health literacy in CHB #WPSD2023 @AmyEByrne93 @nalaireland @DyslexiaIreland @NPQD_CHB @HSCPConnolly

Sarah McCarthy @smccart6 · Sep 18

A great morning in OLOL Drogheda celebrating World Patient Safety Day. Meeting with staff and patients and chatting about #patientsafety. A special thank you to Orla Kenny, Patient Engagement Manager RCSI. #WPSD23 @EmilyMMaguire @NursingOlol @NationalQPS @HealthPromoOLOL

HSE CHO DNCC @HSECHODNCC · Sep 13

World Patient Safety Day 2023 events are taking place across @HSECHODNCC this week. Pictured are Vincy Varghese and Siobhán Carrigan (Quality & Patient Safety Advisors) at a promotional event for the new HSE patient booklet entitled "Your Health, Your Voice" #WPSD23 #HSEDNCC

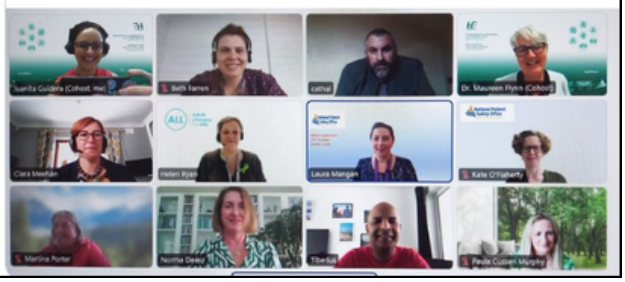
St Vincent's University Hospital (SVUH) @svuh · Sep 19

Come talk to members of our #SVUH Quality & Patient Safety team who are at CentrePoint until 12 noon today to raise awareness about #IncidentManagement in honour of #WorldPatientSafetyDay. Together, we can make healthcare safer for everyone #PatientSafety #WPSD2023

PatientsForPatientSafetyIreland @PFPS_Ireland · Sep 12

Great sharing of so much best practices around the country for #WPSD2023. We urge all healthcare professionals around Ireland to learn and adopt. Thank you @NationalQPS and in particular @juanitaguidera. @WHO @doyle_gerardine @Kris_Sorensen @HSELive @DonnellyStephen @deirdre_dm

> **QPSTalkTime** @QPSTALKTIME · Sep 12
>
> A huge thank you to our fantastic panel for todays QPS TalkTime and of course everyone who joined us and engaged with the session, we hope you found the session informative.
>
> For all World Patient Safety Day resources visit ...
> Show more



saoltagroup @saoltagroup · Sep 21

Staff at #UHG raising awareness for World Patient Safety Day #WPSD2023

"Elevate the patient voice and safety through health literacy".

NMPDU Dublin North @NMPDUDN · Sep 17

On this #WorldPatientSafetyDay our message to you is: if you're not sure, please ask us.
"What do I need to know now? What do I need to do next? What can I expect? How will this help me?
www2.healthservice.hse.ie/organisation/n...
@hselive @nationalqps @patient_for @npsolRL @who #WPSD2023

CNO's Office @chiefnurseIRE · Sep 17

World Patient Safety Day
This year's theme:
"engaging patients for patient safety" in recognition of the crucial role patients, families and caregivers play in the safety of health care #WPSD2023 @npsolRL

> **Department of Health** @roinnslainte · Sep 17
>
> Today is World Patient Safety Day #WPSD2023. Chief Nursing Officer Rachel Kenna @chiefnurseIRE highlights the importance of engaging patients for patient safety to ensure safer, more appropriate, patient-centred care. @WHO_Europe @NationalQPS @ISQua @patient_for @nalaireland

@StColumcillesHospital @StColumcillesH1 · Sep 25

DAY 5When we communicate clearly and with care and compassion, patients have more confidence and trust in us and are more likely to take our advice, and follow medical guidance.
#WorldPatientSafetyDay2023 #WPSD2023 #OpenDisclosure

National Unexpected Intraoperative Life Threatening Haemorrhage Poster

Miriam Kennedy, Project Manager,
Department of Surgical Affairs, RCSI

Basil Sunny, Staff Nurse Orthopaedic OT; Jisha Chaco, CNM2 General OT; Viorel Ivan, CNM2 Anaesthetics; Aleksandra Kos, Staff Nurse Orthopaedic OT and Michael Reeder, CNM2 Neuro OT.

In May 2022, the Department of Health published the National Clinical Guidelines for Unexpected Intraoperative Life Threatening Haemorrhage. The guidelines were developed by the National Clinical Effectiveness Committee (NCEC).

Recommendation 3 of this guideline states that "All Hospitals must have the National Life Threatening Haemorrhage Management Poster prominently on display in the operating theatre."

Why a national poster?

Life threatening haemorrhage has a mortality rate of >10%. Delayed response was associated with a three fold increase in mortality in a case series as reported to the Serious Hazards of Transfusion (SHOT) haemovigilance system. Ready access to a documented, optimised protocol provides clarity as to the key activities and responsibilities across hospital services, to help manage this medical crisis and ensure the best possible outcome for the patient.

A survey undertaken by the Guideline Development Group, of all blood transfusion laboratories across the country, identified common use of a single page protocol within their documentation for the management of life threatening haemorrhage. However, the content and accessibility differed substantially between hospitals. The group worked to develop an optimised single page protocol to standardise practice across all surgical sites and capture key local information in the same format. When staff move between hospitals this standardisation makes it clearer as to the exact process to follow in responding to an emergency event, in turn helping to reduce delays in response time.

This national poster provides a protocol for use in staff education, training and hospital drills. Each relevant staff member should be familiar with the content and it should be readily available in theatre for use as a prompt during a life threatening haemorrhage incident.

Dr. Michael Gill, Consultant Anaesthetist; Mary Kearney, Theatre Manager; Damien Murphy, Theatre Attendant; Brendan Russell Theatre Attendant and Dr. Kate Fitzgerald, Consultant Anaesthetist.

What does the poster include?

High level guidance for theatre staff and other hospital staff is provided in the poster. The Guideline Development Group identified a lack of clarity and understanding about these time requirements across the theatre team. It is hoped listing these on the poster will bring it to everyone's attention.

A very important element of the poster is the space provided to record information specific to your hospital for example:

- The contact details of support external to the operating room, such as switchboard, the blood transfusion laboratory or additional expert /external help for example vascular surgery or interventional radiology.
- The blood components that support managing haemorrhage are listed alongside their location in your hospital and the time required to receive these components in the operating room after they are ordered.

It is recommended that you use indelible ink when recording the hospital specific information on the poster; this will be in-line with antimicrobial infection controls (IPC) for the operating room.

What steps can you take?

- Display this poster which is required in all operating rooms where:
  a. open or laparoscopic / operative intervention in the chest, abdomen or pelvis takes place or
  b. where there is potential to inadvertently enter one of these cavities or cause vascular injury during surgery.
- A project team has worked in recent months to coordinate the distribution of the required quantity of posters to all hospitals in the country. Please make sure that the posters are available and in use in your hospitals and if not, bring it to the attention of your Perioperative Director or relevant Theatre staff member, Lead Haematologist for Transfusion or the Hospital Transfusion Committee.
- All staff working in theatre and all medical scientists involved in a life threatening haemorrhage (including those providing out of hours cover), along with all supporting hospital staff, should participate in regular multi-disciplinary drills in the recognition and management of major blood loss - please ensure the poster is included as part of your drill scenarios.

We need your help in ensuring this poster is in place across our hospitals - we thank you for your support!

The poster is live – is it in place in your hospital?

Click to download the poster.

Open Disclosure Week 2023

At the start of October we celebrated Open Disclosure Week, which saw people across HSE and HSE-funded services come together to recognise the importance of providing opportunities for patients and service-users to actively partner with staff in the open disclosure and incident management process.

National Screening Service team members

Open Disclosure leads and service users at Clonskeagh Nursing Unit

This years Open Disclosure Week continued the theme of the World Health Organisation, World Patient Safety Day which focused on 'Elevating the patient voice'. Building on this important work, people across services delivered a range of activities which promoted the understanding that when patients are treated as partners in their care, significant gains are made in patient safety, patient satisfaction and health outcomes.

Open disclosure leads and trainers in services across the country delivered a fantastic variety of engagement activities to promote the message. Performing this role in addition to their full-time job, open disclosure leads were ambitious and creative in their approach to developing activities. On a daily basis these highly knowledgeable and experienced individuals engage with people in services who have a range of understanding about Open Disclosure and must meet them with the right level of information. Equally, they understand that engagement with patients and the public is an important part of the week. Activities included information and promotional stands in public areas to meet patients/service-users directly to share resources and discuss how Open Disclosure and health literacy might help to elevate their voices.

To amplify this messaging, Patients for Patient Safety Ireland and the Patient Advocacy Service launched supportive messaging including a series of videos through social media. These videos aimed to highlight the crucial involvement of the patient/service-user in incident management and the importance of advocacy and the supports available during this process.

The week was also an opportunity for services to ensure that staff are aware of their obligations in relation to Open Disclosure and are compliant with mandatory training requirements. In particular, we emphasise the importance of providing the opportunities for patients and service-users to actively partner staff in the Open Disclosure process.

Resources developed by the National Open Disclosure Office are aimed to support services with the delivery of their many local activities. These include training events, promotion of e-learning training, communication articles and templates for facilitating supported discussions at team meetings.

It was great to see a significant increase in the uptake of open disclosure training, both online and face-to-face training. Services also used the week as an opportunity to promote the importance of open disclosure documentation, including the launch of sticker templates in some services.

The staff in the National Open Disclosure Office of the Quality and Patient Safety Incident Management Team would like to sincerely thank all of the patient partners, open disclosure area leads, site leads, trainers, managers and staff and all who engaged in promoting Open Disclosure during this week. Equally, the week would not be possible without the support of colleagues across NQPSD and HSE Corporate teams. We look forward to continuing this work and welcome your feedback on this year's Open Disclosure Week.

You'll find resources, policies and templates for Open Disclosure on the National Quality and Patient Safety Directorate website.

CHO Dublin North Country Council team members and service users

Insights on the Patient Safety Act and National Open Disclosure Framework

In conversation with Lorraine Schwanberg, Assistant National Director for Quality and Patient Safety (Incident Management, Open Disclosure and NIMS)

Access more detailed information here.

In May of this year, the President enacted the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (the Act) and on the 19th October 2023, the Department of Health launched the National Open Disclosure Framework (2023) (the Framework). It is expected that the Act will be commenced in summer 2024 and as set out in the Framework, healthcare providers will need to report on open disclosure to the Minister for Health in an annual report from 2025/2026 onwards. In this article, Lorraine Schwanberg, shares insights on both.

> **"The overarching aim of both the Act and the Framework is that they seek to further embed a culture of openness and transparency across the Irish healthcare system and that this is supported with good documentation."**

Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

What changes will the Act bring?

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 places a legal requirement to undertake open disclosure for a list of 13 specific incidents. Click to access more detailed information about the Act and the Notifiable Incidents. The Act includes some key amendments to current legislation, in particular Part 4 of the Civil Liability (Amendment) Act 2017 (CLA Act).

The CLA Act as it currently applies and its accompanying regulations put voluntary open disclosure on a legal footing. However, it also introduced the requirement of the completion of a number of forms that need to complete as part of the open disclosure process to indemnify the content of the open disclosure meeting discussion and the apology. The Act once commenced, amends the CLA Act to align it with the process outlined in the Patient Safety Act for making an open disclosure. This will lessen the administrative burden on those involved.

Additionally, another issue the Act addresses which has come to the fore concerns the open disclosure meeting. There has been some ambiguity as to what might qualify as such a meeting. The legislation sets out clearly what is required for a meeting to be deemed an open disclosure meeting as per the Act. Whilst this might read as prescriptive, when it is broken down, it outlines some of the basic points of discussion a person may expect and want as a patient/service user or relevant person of the patient/service user.

Prior to the open disclosure meeting of a Notifiable Incident (NI) the health service provider must identify a designated person who works for the health service provider. The designated person will support the patient/service user and relevant person [1] throughout the open disclosure process.

The Act describes that where the health service provider has determined that an apology is to be made in relation to a notifiable incident that it may be made at the open disclosure meeting. The HSE Open Disclosure Policy reinforces the need for an apology.

Realistically, a health practitioner undertaking the meeting will only be able to comment on the facts as they are known to them. It is not expected that there will be an unreasonable ask on a health practitioner to determine with surety what future consequences the incident might have on a patient. In the majority of the current Notifiable Incidents, the patient/service user has sadly died [1]. The Minister may add to the list of Notifiable Incidents in the future.

[1] Commentary on the Act refers to the health service provider's obligations to the relevant person of the patient/service user because the list of notifiable incidents mostly relate to incidents where a patient/service user died or is an infant.

What information should be provided at an Open Disclosure meeting as per the Act?

The meeting, which should generally be in person, should provide:

- **An introduction and the names of the persons present at the open disclosure meeting**
- **A description of the incident concerned (including date of the incident where known)**
- **When and how the health care provider became aware of the incident**
- **If the health service provider is aware of whether or not the incident led to any physical or psychological harm for the patient/service user (acknowledging that predominantly for the current list of NIs the patient is deceased)**
- **Where the health services provider has reasonable grounds for believing that in addition to the consequences referred to already, what future harm might develop (physical or psychological) or not.**
- **Where, at the time of the incident disclosure meeting there was harm identified (physical or psychological), the health service provider shall inform the patient of the treatment, and relevant clinical care, that the provider is providing (or proposes to provide) to the patient / service user to address those consequences**
- **Lastly, having regard to the consideration, by the health services provider, of the notifiable incident**
  (i) the actions the health service provider has taken, or proposes to take, and
  (ii) procedures or processes to be implemented, in order to, in so far as it is reasonably open to that provider to do so, address the knowledge the provider has obtained from its consideration of that incident and the circumstances giving rise to it.

So while the requirements of the Act are clear in relation to the open disclosure meeting and can be fulfilled in any clinical setting, the HSE has learned from experience that it is important that the patient/service user or their relevant person:

- has their own support person with them if they so wish,
- understands the purpose of the meeting and the content of the discussion, and
- can ask questions.

This is not stipulated in the legislation but something the HSE emphasises. The legislation does however put a legal requirement on the need for a designated person to liaise with the health services provider and the patient or relevant person (or both of them) in relation to the open disclosure of the Notifiable Incident and any requests for clarification.

Is there a legal requirement to document the Open Disclosure meeting under the Act?

Yes. The Act further sets out the need to document the conversation. The meeting needs to be followed-up in writing within five days. Importantly, following on from any open disclosure meeting, is that the lines of communication remain open through the designated person who will be the point of contact for the patient/service user or their relevant person.

How will the Act be implemented?

The HSE has set-up an implementation group looking at some of the key requirements of the Act with particular focus on the provisions surrounding clinical audit, screening, notifiable incidents, open disclosure and the technical changes required to better report open disclosure on NIMS and to be able to report to HIQA/ Chief Inspector and the Mental Health Commission from NIMS.

We will be revising the HSE Open Disclosure Policy to standardise the approach for all incidents where there was harm and we will develop resources, update our training and develop templates for the meetings/letters. to support our colleagues in the process.

National Open Disclosure Framework

How will the Framework impact culture?

The 2023 Framework is also a positive development that will help support a culture of openness and transparency because it describes a system-wide approach to the implementation of open disclosure. It addresses regulators and academic institutions and makes it everyone's responsibility to support its implementation, including both public and private health care providers.

The reference to and requirement of a Just Culture is welcome. It is a key area of focus for us in the HSE. It recognises that staff must be treated in a fair and just manner following a patient safety incident and that predominantly such incidents occur because of system failings rather than individual acts or omissions.

How is the HSE involved in the implementation of the Framework?

The HSE will be implementing the Framework in full; however, there are two particular areas that the HSE is working on in terms of implementing the National Open Disclosure Framework.

First, there is a requirement for clinical and managerial champions to lead and promote open disclosure policy, education, and training, and monitor practice within health service provider settings. There is already a fantastic network of open disclosure leads in the different organisations that are predominantly quality and patient safety staff. There are however few clinical leaders who have taken on such a role. Clinical open disclosure champions will be an area of focus for us as we envisage that they will heavily influence culture and embed open disclosure amongst peers.

Secondly, healthcare providers will be required to report to the Minister for Health on their open disclosure policy implementation, their clinical and managerial champions, training compliance and the number of open disclosure events in their organisation. It is important that we make technical changes to the NIMS system to accurately capture and report on the number of incidents where open disclosure is required and to capture compliance against key steps of the open disclosure process (that is the open disclosure meeting, follow-up of the meeting with a letter and that the review report was shared with the patient/service user or relevant person).

So whilst there is some work to do, we are on a good path. The journey is positive and the forthcoming changes will strengthen open disclosure. We will share regular updates on developments and the team and I would be delighted to speak to you regarding both.

How can you get involved?

We are currently undertaking consultation on the interpretation of the notifiable incidents. If you would like to contribute and feedback or you work in a specialty where they specifically apply and your group would like to contribute, then please do get in contact. You can contact me or the team at opendisclosure.office@hse.ie.

Pictured from left to right: Sean Egan, Director of Health Regulation, HIQA; Catherine McHugh, Consultant Endocrinologist, Sligo University Hospital; Bernie O'Reilly, member of Patients for Patient Safety Ireland; Carolyn Donohoe, Director of Education, Policy and Standards, Nursing and Midwifery Board of Ireland (NMBI); Maurice O'Donnell, Head of Patient Safety Legislation and Advocacy; Lorraine Schwanberg, Assistant National Director (Open Disclosure, Incident Management, NIMS), National Quality and Patient Safety Directorate (NQPSD); Angela Tysall, HSE Lead Open Disclosure, NQPSD; and Georgina Cruise, National Manager of the Patient Advocacy Service

Update on the development of the National Quality and Patient Safety Competency Framework

The first co-design workshop for the development of a National Quality and Patient Safety Competency Framework was held in Dublin on 12th July and was attended by 33 people from across the health service, patients and academic partners.

The event was opened by Dr. Mary Browne, Clinical Lead for QPS Education and facilitated by Dr. Aoife DeBrún and Dr. Dimuthu Rathnayake from UCD with support from staff from the National Quality and Patient Safety Directorate, Enterprise Risk and patient partners.

Using a World Café style workshop, many quality and patient safety themes from other competency frameworks around the world were explored, a number were selected as appropriate for the Irish context and others were added based on the knowledge in the room.

A team from UCD have collated the results from this first workshop and in collaboration with the NQPSD Education Team, are planning the next phase of the co-design process.

Where can you find out more information?

If you would like to learn more about this project, email: Stephanie.Horan@hse.ie or Dimuthu.Rathnayake@ucd.ie. Learn more on our website.

Pictured above are participants at the first co-design workshop for the development of a National Quality and Patient Safety Competency Framework.

Latest from Patient Safety Together

News

Patient Safety Together: learning, sharing and improving

New HSE National Patient Safety Alert: Medical Device Regulation and CE Marking

A medical device is a product, piece of equipment or system that is intended by its manufacturer to be used for a medical purpose to treat, diagnose, or manage illness, injuries, or other health issues. Medical devices also include certain software used for diagnosis, prediction, or treatment planning. Within the EU, medical devices are regulated under the Medical Device Regulation (MDR) (EU) 2017/745 which came into effect in Ireland on May 26th 2021. Medical device regulation is further upheld by the Health Products Regulatory Authority (HPRA). A medical device intended to be used in HSE/HSE funded services must be CE marked to indicate that it meets regulatory safety and performance requirements. CE certificates are issued by independent certification organisations called notified bodies.

When a medical device is in development and does not yet have a CE mark, there are two exceptional circumstances under which it can be used: clinical research or compassionate use. In both instances, an application to the HPRA for authorisation for use of the medical device is required.

New HSE Patient Safety Digest

This edition includes a collection of 23 articles and four reports/webpages that relate to quality and patient safety. They are sourced from high quality, national and international peer-reviewed periodicals. The Digest also includes two recently published Direct Healthcare Professional Communications (DHPC) containing important new medicine safety information approved by the Health Products Regulatory Authority (HPRA).

New Spotlight Series

Patient Safety Together are also delighted to introduce our 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 the first instalment, Patient Safety Together were delighted to collaborate with the College of Anaesthesiologists of Ireland. Through their ongoing work and commitment, the College are demonstrating great leadership in their profession; leadership that is prioritising patient safety and a positive learning culture.

New Patient Safety Supplement: Recognising surgical site infection at home

This Patient Safety Supplement focuses on surgical site infection and supports patients to identify a surgical site infection following discharge from hospital.

Patient Safety Stories:

Just Culture - staff experience

This is the story of a staff nurse involved in an incident and the lessons learned when incidents or near misses occur.

My journey as a patient - a staff member story

This is a story from a staff member who became a patient in the service where she worked.

For further information, see www.hse.ie/pst or contact the team at patientsafetytogether@hse.ie

Coaching for Improvement

Supporting the people who help others improve

Latest from Veronica Hanlon, Educationalist, National Quality and Patient Safety Directorate and Bríd Murray, Leadership, Learning and Talent Management

Education and training in quality improvement (QI) methodology is important for all those working in healthcare to help them understand the principles of QI and be able to use the many QI tools available to them to provide better, safer healthcare. Over the last decade, the National Quality and Patient Safety Directorate has been offering QI training to staff through a number of learning programmes aligned to the HSE QI Learning Pathway. Having the knowledge and skill however, is only one aspect of making an improvement happen and more importantly, making it sustainable.

Transferring QI learning to practice

Some healthcare teams are able to quickly apply the learning and make significant improvements to the service or care that they provide. In contrast, many report leaving the classroom full of enthusiasm, but later feeling discouraged and frustrated with their lack of progress. The reason why improvement projects fail or don't sustain is not due to a lack of motivation of those trying to improve, but more often due to competing demands on staff and services with little priority, protected time or support given to QI. Identifying local QI Coaches available to teams as they embark on a QI journey can be a key factor in implementing successful QI projects. According to the World Health Organisation (WHO):

"QI coaching is an important method to provide ongoing support to help healthcare workers and teams to apply QI approaches in their setting."

Who can coach others to make improvements?

Anyone who has an understanding of QI methodology can help others make improvements. This could be a line manager, a colleague, a QPS manager or an advisor. However doing so in a 'coaching' style is much more effective to help teams learn. In 2022, a training needs identification survey of Quality and Patient Safety (QPS) managers and advisors across the health service identified coaching skills as one of the key requirements for those working in QPS supporting and advising roles.

Many managers in the health service have undergone some form of QI education and training but often find it challenging to move from the role of 'doing' and 'telling' to that of 'coaching' when it comes to quality improvement.

So what is coaching?

Tim Galloway (1974) in his seminal book The Inner Game of Tennis, which has been applied to the fields of business, health, and education defined coaching as "unlocking a person's potential to maximise their own performance. It is helping them to learn rather than teaching them". Becoming a life or executive coach takes formal training and accreditation, but as healthcare workers, we can all develop key coaching skills that can be used in everyday practice to help and support others to improve the quality and safety of care being provided.

What are the key coaching skills?

How can I develop these coaching skills?

The QPS Education team in collaboration with the Human Resources Leadership, Learning and Talent Management department have combined their expertise to design and deliver a one-day Coaching for Improvement Programme. This programme is delivered virtually and provides an opportunity for participants to learn about the key coaching skills and how they can be applied to QI while having an opportunity to practice in a safe space. The programme is eligible for CPD points from RCPI and NMBI.

> The programme was an insightful experience for me…one of the most valuable takeaways for me was the emphasis on adopting a coaching-style in quality improvement conversations. By implementing the coaching approach, I found that communication with my team improved significantly, fostering a culture of open dialogue and continuous growth
>
> Alison Dwyer,
> Clinical Facilitator

> I have utilised the GROW model in a recent conversations with a member of staff. I feel it has empowered this person to take ownership of their improvement journey and strive to make positive changes.
>
> Selene Daly
> Clinical Audit Facilitator

Can I register for this programme?

Anyone working in health and social care services actively involved in supporting or facilitating teams to deliver quality improvements can apply by emailing qps.education@hse.ie

Latest episode from the All Ireland podcast: Walk and Talk Improvement!

It's not about the big things:

Leaders on Leadership

In this episode, we are speaking with two leaders in nursing and midwifery about how they are creating a culture of safety for people, with a particular focus on women and babies in maternity services across Ireland and Northern Ireland. Our two guest's share:

- Their examples of how they are overseeing and improving services.
- Times when things did not go as expected, and what they have learned.
- Simple steps you can take to get involved in patient safety improvement.

Featuring:

- Grainne Milne, Director of Midwifery, HSE Louth Hospitals, Ireland
- Denise Boutler, Assistant Director, Quality, Safety, Patient Experience and Innovation, Public Health Agency, Northern Ireland.

Hosted by: Dr Maureen Flynn, Director of Nursing, Office of the Nursing and Midwifery Services and National Quality and Patient Safety Directorate, HSE.

Bearing witness:

Through life and death

In this episode, we explore the impact of patient partnership on the development of the HSE National Clinical Guidelines for Post Mortem Examination Services. We speak with members of the working group on why patient partners became involved in this important work and their role in helping maintain the patient and family perspective in the Guidelines. Our guests also share what you can do as a leader to create meaningful engagement with patient partners.

Featuring:

- Professor Linda Mulligan, Chief State Pathologist
- Mairie Cregan, member of Patients for Patient Safety Ireland

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

Healthcare professional's experience of clinical audit with the HSE National Centre for Clinical Audit

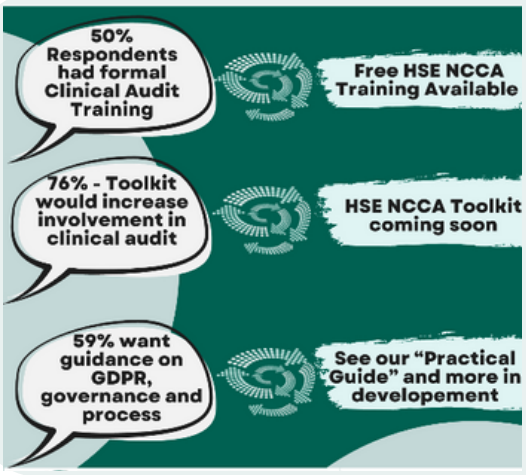
The National Centre for Clinical Audit (NCCA) conducted a survey exploring healthcare professional's experiences in clinical audit.

> **"As the HSE NCCA leads on the implementation of best practice in clinical audit across the healthcare landscape, this survey was essential to understanding the experiences of those involved in clinical audit at a local level."**
>
> Karen Reynolds, HSE NCCA.

The survey yielded 238 responses from healthcare professionals of varying clinical backgrounds. It showed that whilst 88% of respondents had previous involvement in a clinical audit, only 50% had received formal clinical audit training, illustrating a clear requirement for provision of clinical audit training within the HSE. Free, CPD accredited training is available from the NCCA. Findings from this survey will inform the development of the NCCA's training and education strategy for 2024.

Furthermore, 76% of respondents identified that the provision of a clinical audit toolkit would make them more likely to be involved in clinical audit, whilst 59% sought further advice on governance, GDPR and other procedures for clinical audit. The NCCA will launch a Clinical Audit Toolkit in the coming weeks, which will be followed soon after by a Data Protection and GDPR FAQ document.

The HSE National Centre for Clinical Audit (NCCA) promotes clinical audit as an essential quality and patient safety tool in Irish healthcare. The survey was completed as part of the Clinical Audit Awareness Week (CAAW), an annual campaign to promote clinical audit which was celebrated internationally from 19th - 23rd June. During the week, over 182 viewers participated in a "Learn at Lunch Webinar" hosted by the NCCA and its partners - the National Office of Clinical Audit and the Clinical Audit Support Centre (CASC UK).



To read the full survey report and explore the training opportunities and resources, visit NCCA's website.

Interested in making a difference through quality and patient safety?

PRINT AND SHARE
Expand your knowledge through free resources from the HSE National Quality and Patient Safety Directorate.

Watch our QPS TalkTime Webinar series

QPS TalkTime
A community of quality and patient safety improvers

SCAN ME

Join our fortnightly free webinar to hear from national and international experts and those improving QPS throughout our health service. Participate as an individual, with a group or listen to our catalogue of past episodes.

Read Quality and Patient Safety Matters #AllThingsQuality

SCAN ME

Our quarterly newsletter shares QPS news, your QPS stories, educational content and upcoming training, events and networking opportunities.

Watch out for our upcoming edition in early November on “Elevating the Patient Voice” - the theme for World Patient Safety Day.

Join Patient Safety Together: learning, sharing and improving

Patient Safety Together: learning, sharing and improving

SCAN ME

We are building a national community for staff working in QPS in HSE / HSE-funded services. Access up-to-date patient safety information through alerts, supplements and stories.

Explore the Collaborative Handbook

SCAN ME

This handbook is your compass to successfully lead, plan and implement an Improvement Collaborative.

1. step-by-step guidance with worked examples for organising and leading collaboratives.
2. integration of toolkits, templates and resources for data-driven results.
3. tried and tested to tackle challenges across healthcare sectors.

Listen to our Walk and Talk Improvement Podcast

SCAN ME

This All Ireland podcast aims to improve patient care by capturing the personal stories of people who work in and use health services. The series is co-produced by patient partners and members of the Health and Social Care Quality Improvement (HSCQI) Northern Ireland and HSE NQPSD team. It is available wherever you listen to your podcasts.

Join Q Community

SCAN ME

Q is an ambitious, long-term initiative that brings together people working to improve health and care. It is led by The Health Foundation and supported by five country partners across the UK and Ireland.

It is an exciting opportunity for improvers in Ireland to connect and collaborate with fellow improvers, use Q as a source of innovation and practical problem solving and get involved with a range of activities and benefits that are on offer, including training, resources and funding. It is free to join.

Your Health, Your Voice

SCAN ME

Almost one in three people in Ireland have difficulty accessing and understanding health-related information. Asking or answering questions help:

- What do I need to know now?
- What do I need to do next?
- What can I expect? How will this help me?

Access “Your Health, Your Voice” resources for people using and delivering healthcare via the QR Code.

For more information

SCAN ME

Visit our website to find out more including for example:

- Reporting and managing an incident
- Applying to become a Q community member
- NQPSD Research
- Preparing for and managing Open Disclosure
- Using human factors thinking
- Sepsis

Follow us on:

Website	www.hse.ie/nqpsd
Twitter	@NationalQPS
LinkedIn	HSE National QPS Directorate
YouTube	HSE National QPS

Upcoming events

Upcoming training, events and networking quality and patient safety 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 Winter series

Dates for your diary: 21st November 2023 and 5th December 2023

Patient Safety Together Community

Dates for your diary: 23rd November 2023 with a focus on clinical audit. Email patientsafetytogether@hse.ie for information on how to join the community.

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

Dates for your diary: 17th January 2023

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 third 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 January 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.

Spotlight on upcoming training

National Centre for Clinical Audit Training

Advanced Clinical Audit Course

22nd Nov 2023

Fundamentals Training in Clinical Audit

7th Dec 2023

Walk and Talk Improvement - Latest Episodes

Episode 7 - It's not about the big things: Leaders on Leadership

Episode 8 - Bearing witness: through life and death

Two new episodes to be released this year:

- Episode 8: Bearing witness: through life and death part 2
- Episode 9: Deconditioning

The series is available on Spotify, Amazon Music Prime, YouTube and Google Podcasts.

Prospectus of Education, 2024

The 2024 Prospectus of Education and Learning Programmes will be released in January 2024. The 2024 Prospectus will be launched on the National Quality and Patient Safety Directorate website.