Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences

The Quality and Patient Safety Competency Navigator

What students, staff and patients need to know and be able to do to improve quality and patient safety in healthcare.

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Date	Version	Created by	Reviewed by	Final document approved by
10th January 2025	01	QPS Competency Framework Project Team	QPS Competency Framework Advisory Group	Dr Orla Healy, National Clinical NQPS

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Foreword

Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

National Quality and Patient Safety works in partnership with healthcare providers, staff, patients and families to improve patient safety and quality of care.

A key commitment of our team is to enable students, staff and patients to improve quality and patient safety and we do this by supporting a culture of continual learning. We also work as a team to build quality and patient safety knowledge, skills and behaviours across health services.

As the National Clinical Lead for Quality and Patient Safety, I'm delighted to present the QPS Competency Navigator. This is the outcome of a two-year collaboration with the UCD Centre for Interdisciplinary Research, Education and Innovation in Health Systems (UCD IRIS) at the School of Nursing, Midwifery and Health Systems. It also involved an extensive co-design process with staff, patients, academics and other stakeholders.

We hope this resource will help you to identify the quality and patient safety competencies that you need for your role and sign-post you to relevant learning resources. Whether you are designing quality and patient safety learning programmes or planning your own personal and professional development, the QPS Competency Navigator will help you on your quality and patient safety learning journey.

Dr Orla Healy
HSE National Clinical Lead for Quality and Patient Safety

PLAY VIDEO

Message from the Chief Clinical Officer

Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

I am delighted to launch the first National Quality and Patient Safety competency framework for the Irish health service. Quality and patient safety are fundamental to our delivery of good care. Good care is underpinned by knowledge and skills gained from in-practice development, undertaking learning programmes, and keeping up to date with guidelines, policies, standards, and relevant research.

As we transition to HSE regions, it is essential that we enable all staff to deliver quality, safe services by supporting learning and improvement across our system. This Quality and Patient Safety Competency Navigator will support students, staff, leaders, patients and patient partners on their quality and patient safety learning journey.

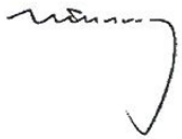
This Navigator serves as a map and a guide, reflecting the fact that the competencies we need will depend on our role within the health service and that they are developed throughout our careers. It is designed to help people to self-assess and identify competencies for development, and show how these can be achieved in practice and by providing learning supports at different levels from those aimed at everyone all the way through to expert. I would encourage staff to use the navigator as part of your personal development planning and to develop your knowledge, skills and behaviours to your fullest potential.

This resource has been created through an extensive co-design process with widespread engagement of stakeholders including services users and patient partners, staff from across the wider health service, and educational, professional and regulatory bodies, who have all given generously. This approach has ensured that this competency navigator is relevant, useful and usable, and has been designed by staff and patients for staff and patients.

As Chief Clinical Officer, my aim is to support staff in developing competencies in quality and patient safety and putting these into practice. In reflecting on the continuous learning journey that those working in or using healthcare embark upon, this navigator will be a dynamic document, changing over time to reflect new research, guidelines, learning opportunities, or ways of working.

I would like to extend my sincere thanks to the patient partners and service users, staff and stakeholders who engaged in and contributed to the workshops. My particular thanks and acknowledgement to NQPS and our colleagues from the UCD Centre for Interdisciplinary Research, Education and Innovation in Health Systems (UCD IRIS) at the School of Nursing, Midwifery and Health Systems who supported the development of this document.

PLAY VIDEO



Dr Colm Henry
HSE Chief Clinical Officer

Acknowledging the engagement and support of the following professional bodies and offices

Office of the Nursing & Midwifery Services Director

Human Resources
Leaders in People Services

HSE

NDTP NATIONAL DOCTORS TRAINING & PLANNING

Health & Social Care Professions

Patients for Patient Safety Ireland

FORUM OF IRISH POSTGRADUATE MEDICAL TRAINING BODIES

National Patient Safety Office
Oifig Náisiúnta um Shábháilteacht Othar

Comhairle na nDochtúirí Leighis
Medical Council

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

An Roinn Sláinte
Department of Health

HMI
Health Management Institute of Ireland

UCD School of Nursing, Midwifery and Health Systems
Scoil an Altranais, an Chnáimhseachais agus na gCóras Sláinte UCD

CORU
Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Bord Altranais agus Cnáimhseachais na hÉireann
Nursing and Midwifery Board of Ireland

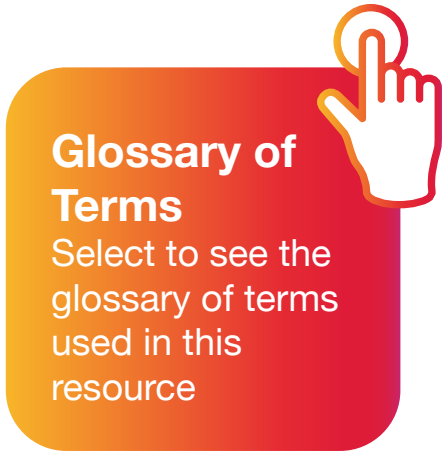
Introduction

What is the QPS Competency Navigator?
The QPS Competency Navigator is a self-assessment tool. It will help you to identify and develop the key competencies (knowledge, skills and behaviours) we all need to provide quality and safe care. It will also sign-post you to relevant educational resources and learning opportunities.

Who can use the QPS Competency Navigator?
This resource is for everyone. Students can use it to develop the skills they need to provide safe patient care. Staff can use it to self-assess their competence. They can also identify their quality and patient safety learning needs and opportunities. Line Managers can use it to guide helpful conversations about professional development. Healthcare educators can use it to inform the design of learning programmes. Finally, patients can use it to learn how they can play a role in supporting quality and patient safety.

How to use the QPS Competency Navigator?
The QPS Competency Navigator describes six topics related to quality and patient safety. You can explore these depending on your role. You can use the tool to identify specific knowledge and skills that you need to develop and discover ways to learn more about a topic.

You can use the QPS Prospectus of Education and Learning Programmes with this resource. This will help you to find further information about relevant learning programmes. You can find the Prospectus here https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/



How to use the Navigator

STEP 1

Select the category that best describes you.

STEP 2

Select the topic you would like to explore from the competency wheel.

STEP 3

Read each competency statement and identify areas for development.

STEP 4

Select the relevant development activities you require and record in your development plan.

Download your development plan template here

STEP 1

Select the category that best describes you

A good place to start is with Everyone working in healthcare.

Depending on your role you may see yourself in other categories too. If so, you can review more than one.

This will help you to identify the competencies that are most suited to your role in healthcare.

Everyone working in healthcare

Everyone involved in the delivery of safer better healthcare. This includes those delivering direct patient care and those in a supportive role. This category also relates to supporting students as they learn.

Team Leaders

Operational and clinical team leaders who lead change within teams and services. They bridge the gap between senior leadership and front line.

Quality and Patient Safety (QPS) Roles and Champions

Staff who work in quality, patient safety, clinical audit, risk, leadership and other aspects of QPS. QPS Champions may or may not be working in QPS but have a particular interest in QPS and want to learn more and do more.

Senior Leaders and Board Members

Senior leaders and board members who set the strategic quality and patient safety goals. They govern and lead the commitment to improving quality and patient safety.

Patients and Patient Partners

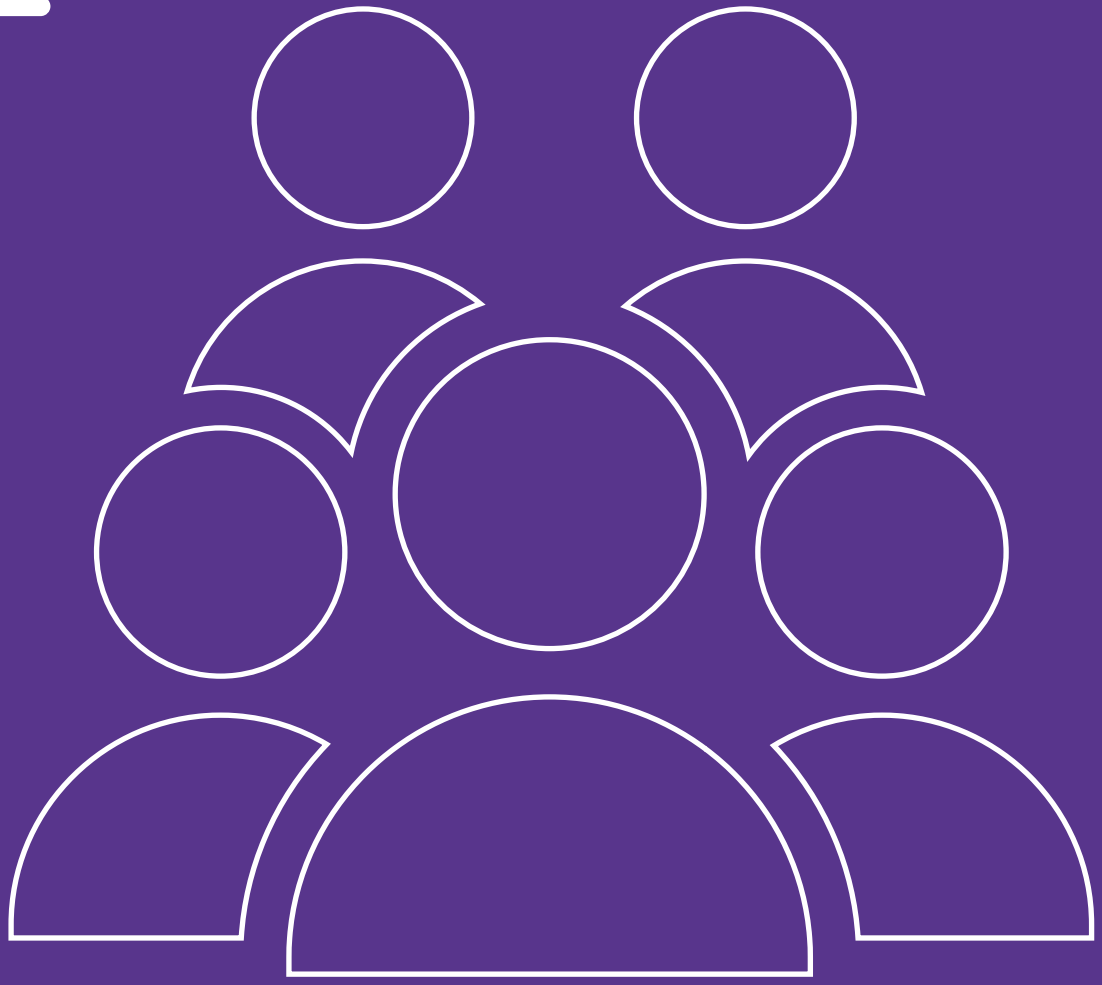
*Patients or those who advocate on behalf of patients. They engage with quality and patient safety work in partnership with healthcare organisations.*When we use the term “patient” we are referring to people who use, or get support from healthcare services. We are also referring to their personal support network, communities and anyone who may use healthcare services in the future.

On the Path to Mastery in Quality and Patient Safety

Those who are passionate about deepening their understanding of quality and patient safety. They influence, coach, educate and support others to improve the quality and patient safety of their organisation.

Everyone working in healthcare

Everyone involved in the delivery of safer better healthcare. This includes those delivering direct patient care and those in a supportive role. This category also relates to supporting students as they learn.



PREV

NEXT

STEP 2

Select the topic you would like to explore

These are the key topic areas for developing quality and patient safety competence. All topics are of equal importance. The number of competencies and range of resources may vary for each.

This Navigator is a dynamic resource. We will add further competencies and resources as areas develop, for example ‘sustainability’.

Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Safety, Risk and Incident Management

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I take part in activities that promote daily quality and safety in health and social care.	
I understand the importance of managing safety by reporting and monitoring risks and incidents.	
I can define my role and responsibilities in identifying, assessing, reporting and responding to risk and safety incidents without delay as per the Enterprise Risk Management Policy, the Incident Management Framework and Open Disclosure policy.	
I understand the importance of assessing risks and learning from safety incidents, including near-misses to prevent future harm.	
I can explain how linking safety, risk and incident management to quality improvement can improve quality and patient safety.	
I can explain how using data and evidence is crucial for managing risks and safety effectively.	
After an incident, I take care of the safety and well-being of everyone involved. This includes patients, families and staff.	
I understand the importance of being open and transparent when things go wrong.	
I support colleagues and peers following a safety incident and do not blame them for what went wrong.	
I can define my responsibilities in relation to safeguarding and follow the policies and procedures in my organisation.	

What this looks like

Takes personal responsibility to anticipate, identify, reduce, and mitigate risks in everyday practice.

How to learn more about Safety, Risk and Incident Management

Learn while you work (in-practice development opportunities)

1. Take part in conducting a risk assessment for your area using the risk assessment tool.
2. Attend a risk register review meeting.
3. Review incident trends in your area.
4. Take part in safety huddles or safety pauses in your area.
5. Get involved in patient safety audits to evaluate compliance with safety protocols and to identify areas for improvement.

Read a Policy, Procedure or Guideline

Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955

HSE Enterprise Risk Management Policy and Procedures 2023
https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-enterprise-risk-management-policy/

HSE Open Disclosure Policy https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/hse-open-disclosure-full-policy-2019.pdf

HSE Incident Management Framework
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Complete a learning programme

Module 1 – Communicating Effectively through Open Disclosure www.hseland.ie

The Patient Safety Act (2023) www.hseland.ie
The role of the Designated Person in Incident Management and Open Disclosure www.hseland.ie

Enterprise Risk Management – An Introduction
https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/2023-hse-enterprise-risk-management-training/module-1-erm-introduction.html

The Fundamentals of Enterprise Risk Management www.hseland.ie

Situation Awareness for Everyone (SAFE) Collaborative. See QPS Prospectus
https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Safeguarding adults at risk of abuse www.hseland.ie
An introduction to Children First www.hseland.ie

Further Learning

HSE Enterprise Risk Management Website
https://www.hse.ie/eng/about/who/riskmanagement/

HSE QPS Incident Management Website
https://www2.healthservice.hse.ie/organisation/qps-incident-management/

Patient Safety Together https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Partnering with People for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I recognise the value and importance of people working together to improve healthcare services.	
When I interact with someone I communicate openly. I am kind, respectful and considerate.	
I provide information that is accessible and understandable for patients so that they can make informed choices about their own care and treatment.	
I encourage people who use healthcare services to ask questions and to share feedback and ideas for improvement.	
I discuss feedback and ideas from patients when working to improve services.	
I understand the concepts and value of person-centred care.	
I understand the importance of making health services equal and accessible for all, in a way that acknowledges and values diversity.	
I aim to improve the participation of vulnerable and excluded groups in health service design, planning and evaluation.	

What this looks like

I actively engage in partnering with people to design and deliver safer health care.

How to learn more about Partnering with People

Learn while you work (in-practice development opportunities)

1. Seek, capture and share patient feedback.
2. Seek opportunities to collaborate with local patient panels or committees.
3. Keep patients informed about how we use their feedback.
4. Learn more about the Patient/Service User Engagement Officer for my region/area.
5. Involve patients and their families in creating care plans, ensure they have a voice in the treatment process and foster shared decision-making.
6. Avail of opportunities to partner with people to improve services.

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources for partnering with people: https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

Complete a learning programme

My health - My voice https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/wpsd-2024/

An Introduction to Diversity, Equality and Inclusion www.hseland.ie

Working in a Diverse Team www.hseland.ie

Adult Literacy for Life Programmes
https://www.adultliteracyforlife.ie/aware/lets-talk-about-health-literacy-course/
https://www.adultliteracyforlife.ie/aware/lets-talk-about-literacy-friendly-approach-course/

Further Learning

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/

AHRQ Patient and Family Engagement: https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

HSE National Office for Human Rights and Equality Policy
https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/

QPS Talk-Time Webinars on Patient Partnership
https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Walk and Talk Improvement Podcasts: The importance of patient partners.
https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality Improvement and Clinical Audit for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I know what quality means and how to recognise it, or its absence, in my area of work.	
I understand that quality improvement is part of my role and responsibility.	
I support quality in my role. For example, by finding opportunities for improvement and innovation, gathering and interpreting data, testing new ideas, and speaking up for quality and patient safety.	
I know how to engage patients and colleagues to identify opportunities for planning, improving and maintaining quality.	
I have a basic understanding of the clinical audit process and how to take part in a clinical audit.	
I take part in quality improvement research.	

What this looks like

I contribute to planning, improving and maintaining quality in my role and my area of work.

How to learn more about Quality Improvement and Clinical Audit

Learn while you work (in-practice development opportunities)

1. Talk to your colleagues and line manager about ways to improve the area in which you work.
2. Work alongside quality improvement and clinical audit experts who can guide staff through the process and share best practices.
3. Review any patient/client feedback.
4. Take part in a clinical audit for your area.
5. Take part in a quality improvement project in your area.
6. Attend workshops that focus on the principles, methods, and tools of clinical audit and quality improvement.

Read a Policy, Procedure or Guideline

Framework for Improving Quality in our Health Service https: https://www.lenus.ie/handle/10147/611719

Quality Improvement Toolkit https://www2.healthservice.hse.ie/organisation/qps-education/quality-improvement-toolkit/

Improvement Knowledge and Skills Guide https://www2.healthservice.hse.ie/organisation/qps-education/knowledge-and-skills-guide/

Clinical Audit – A Practical Guide https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf

Complete a learning programme

Introduction to Quality Improvement www.hseland.ie

Foundation in Quality Improvement www.hseland.ie

Working as a Team for Improvement www.hseland.ie

Fundamentals of Clinical Audit www.hseland.ie

Delivering Change in Health Services - Complete Guide www.hseland.ie

Further Learning

QPS Improvement Website https://www2.healthservice.hse.ie/organisation/qps-improvement/

National Centre for Clinical Audit Website https://www2.healthservice.hse.ie/organisation/ncca/

Q – A community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care. https://q.health.org.uk/get-involved/events/

NOCA (National Office of Clinical Audit) https://www.noca.ie/

Communications, Teaming and Systems

Select the Play button to learn about this topic and to find out why it is important in healthcare.

Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

Select the page icon to view a transcript of the video

Ciarán McCullagh
National Ambulance Service

PLAY VIDEO

Select the page icon to view a transcript of the video

Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

PLAY VIDEO

Select the page icon to view a transcript of the video

Communication, Teaming and Systems for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I communicate effectively with patients, families, carers, teams and the people I work with.	
I know the importance of good communication in ensuring quality, safe care and I can recognise the negative impact that poor communication can have.	
I use communication tools to support effective and clear communication.	
I accommodate different communication needs. For example, literacy, translation, hearing and cognitive abilities of patients and the people I work with.	
I am aware of the legal basis around communicating with patients. This includes confidentiality, data protection, assisted decision making, consent and associated legislation. I understand how and with whom we can share information.	
I give, receive, seek and act on helpful feedback to support my own learning and that of my team.	
I use suitable approaches to manage interpersonal conflict in teams.	
I understand what Human Factors is, and how different components of a health system can interact with each other to influence patient outcomes, staff well-being and system performance.	
I work with others to ensure our work environment, our tools, and processes are safe and support the delivery of quality care.	
I know where my role fits within the system I work in.	
I know the importance of having situational awareness and the factors that can help or hinder it.	
I know the importance of sharing learning from what goes wrong and what goes well.	
I understand that healthcare is always changing and that we need to be flexible and adaptable to keep quality and safety at the centre of everything we do.	

What this looks like

I communicate effectively, apply the skills of teaming and principles of human factors and systems to improve patient care and outcomes.

How to learn more about Communication, Teaming and Systems

Learn while you work (in-practice development opportunities)

1. Get to know your team and their role and responsibilities.
2. Ask for feedback on your communication skills.
3. Take part in debriefing sessions to analyse incidents and near misses. For example After Action Reviews or Systems Analysis Reviews. This will help to uncover how human factors contributed to these events.
4. Attend and/or take part in 'huddles'.
5. Take part in simulation scenarios that mimic real-life clinical situations which promote effective teamwork and role clarity and foster skills like communication and coordination.
6. Take part in team meetings/debriefings.

Read a Policy, Procedure or Guideline

An Introduction to Human Factors for Healthcare Workers
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf

Health Services Change Guide
https://www.hse.ie/eng/staff/resources/changeguide/

HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

Complete a learning programme

HSE Corporate Induction i-Start Hub on www.hseland.ie

Introduction to Human Factors www.hseland.ie

Working as a Team for Improvement www.hseland.ie

National Healthcare Communication Programme
https://www.hse.ie/eng/about/our-health-service/healthcare-communication/

SAFE (Situational Awareness for Everyone) – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Further Learning

Irish Human Factors and Ergonomics Society
https://ihfes.org/

Clinical Human Factors Group – The Health Foundation
https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group

A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19

The Health Literacy Place https://www.healthliteracyplace.org.uk/

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Sustainability for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the impact climate change has on health and the impact healthcare has on climate	
I know the importance of using healthcare resources wisely and in an environmentally aware way.	
I am committed to finding sustainable ways of improving the quality, safety, and delivery of care.	
I take part in local efforts to promote sustainability and reduce the negative impact to the environment.	
I suggest ways of making the way we work more sustainable to my line manager.	

What this looks like

I prioritise sustainability to ensure quality and safe healthcare for the long term.

How to learn more about Sustainability

Learn while you work (in-practice development opportunities)

1. Attend workshops or seminars that focus on environmental sustainability in healthcare, waste reduction, energy efficiency, and eco-friendly practices.
2. Recognise opportunities to reduce waste in your area.
3. Use QI or LEAN methodologies to reduce waste.
4. Join a sustainability committee or green team in your area that promotes environmental initiatives and peer learning.
5. Consider virtual care and communication where appropriate.

Read a Policy, Procedure or Guideline

HSE Climate Action Strategy
https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Sustainability in quality improvement (SusQI): a case-study in undergraduate medical education
https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-02817-2

Complete a learning programme

RCSI Sustainable Healthcare Online https://www.rcsi.com/online/courses/sustainable-healthcare/course-details

World Health Organisation Online Course https://www.who.int/teams/environment-climate-change-and-health/training

Global Health e-learning https://rise.articulate.com/share/eC-tXqaq7BzR7Kl8N1OGu86Th-gNvArl#/

Email climate.action@hse.ie to enrol on the following e-learning programmes
Waste Reduction
Food Reduction
Water Efficiency for Technical Staff

Carbon Basics – Create an SEAI account to avail of training https://energylink.seai.ie/login

Further Learning

National Health Sustainability Office https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/

17 United Nations Sustainable Development Goals
https://www.un.org/sustainabledevelopment/sustainable-development-goals/

Green Health Care https://greenhealthcare.ie/

Global Health Curriculum for Specialist Medical Training in Ireland https://www.theforum.ie/wp-content/uploads/2023/11/Global-Health-Curriculum-Final-for-Print.pdf

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I know what a culture of quality and patient safety looks like and I understand my role in supporting it.	
I am aware of the principles and values (of my organisation and/or professional group) that promote and ensure quality and safety.	
I understand how local, regional and national governance structures support quality and patient safety.	
I am open to innovation and creativity and I create spaces for sharing learning and celebrate achievements.	
I understand the importance of promoting a culture where staff, patients and families feel safe and are encouraged to speak up when they have concerns about care.	
I use evidence-based strategies to promote quality care and reduce harm to patients.	

What this looks like

I work everyday to support and enhance a culture of quality and patient safety.

How to learn more about Quality and Patient Safety Culture

Learn while you work (in-practice development opportunities)

1. Take part in your organisation's Quality and Patient Safety Committee meetings.
2. Take part in a safety huddle or safety pause.
3. Take part in and learn from staff and patient experience surveys.
4. Engage in efforts to promote a positive environment for staff and patients.
5. Capture and share feedback on what does and doesn't work well to improve quality and safety.
6. Discuss safety data and the impact of harm with your team.
7. Engage in simulation-based training that emphasises safety, focuses on preventing errors, avoiding communication breakdowns and improving teamwork during critical situations.

Read a Policy, Procedure or Guideline

Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955

Improving patient safety culture – a practical guide https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/

Developing Organisational Culture – Guide for the Health Service https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

Complete a learning programme

Introduction to Quality Improvement www.hseland.ie

Foundation in Quality Improvement www.hseland.ie

Fundamentals of Clinical Audit www.hseland.ie

Situational Awareness for Everyone (SAFE) Collaborative – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Further Learning

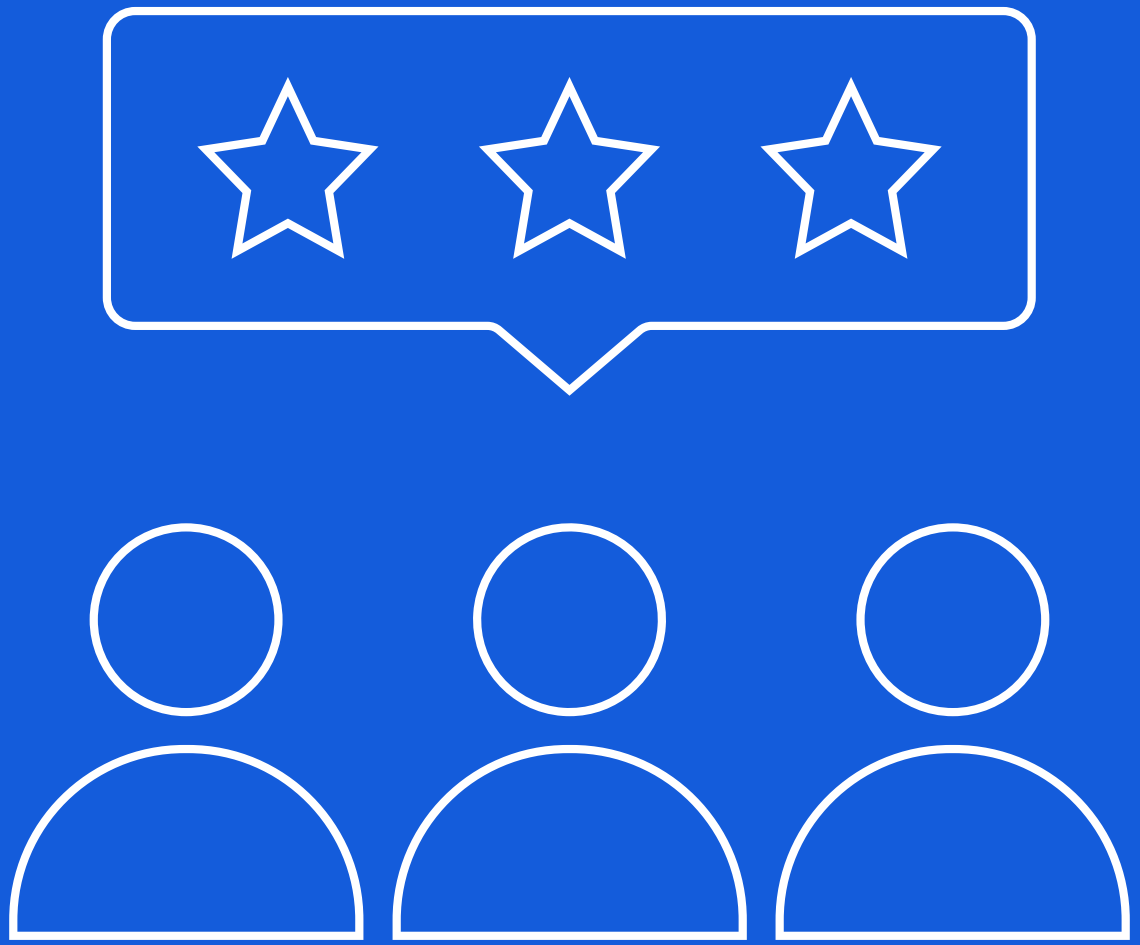
Patient Safety Together: learning, sharing and improving website https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Safety Culture (NHS) https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture/

A Culture of Safety https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/a-culture-of-safety-by-j-fitzsimons.pdf

Team Leaders

Operational and clinical team leaders who lead change within teams and services. They bridge the gap between senior leadership and front line.



PREV

NEXT

STEP 2

Select the topic you would like to explore

These are the key topic areas for developing quality and patient safety competence. All topics are of equal importance. The number of competencies and range of resources may vary for each.

This Navigator is a dynamic resource. We will add further competencies and resources as areas develop, for example ‘sustainability’.

Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Safety, Risk and Incident Management for Team Leaders

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand my responsibilities under my organisation's risk and incident management policies and procedures and ensure that my team are compliant.	
I assess risks based on their likelihood and impact.	
I value and promote person-centred care in risk decision making.	
I manage risk in my area by reviewing risk registers, reporting and reviewing escalated risks and providing assurance on controls and accountability for actions.	
I align my organisation's strategic objectives to my operational plan and service developments and assess any potential risks to achieving same.	
I involve patients and families in discussions about safety incidents and their reviews.	
I facilitate Open Disclosure in line with the specific needs of the patient or their relevant person.	
I review incident reports, incident trends and patient feedback regularly to make improvements to quality and safety of care.	
I use appropriate ways to understand system failures and implement strategies to improve quality and safety for everyone.	
I am aware of my responsibilities in relation to safeguarding and follow the policies and procedures in my organisation.	

What this looks like

I encourage all staff to take responsibility to identify, assess and respond to risks and incidents in their area.

How to learn more about Safety, Risk and Incident Management

Complete a learning programme
Enterprise Risk Management – An Introduction https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/2023-hse-enterprise-risk-management-training/module-1-erm-introduction.html The Fundamentals of Enterprise Risk Management www.hseland.ie Using the HSE Excel Risk Register www.hseland.ie HSE Excel Risk Register 'How-to' video https://youtu.be/W4mEGisgwDw
Module 1 – Communicating Effectively through Open Disclosure www.hseland.ie Module 2 – Open Disclosure - Applying Principles to Practice www.hseland.ie Open Disclosure Face to Face Skills Training – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ The Patient Safety Act (2023) www.hseland.ie The role of the Designated Person in Incident Management and Open Disclosure www.hseland.ie
NIMS Module 1 Training for Incident Entry www.hseland.ie NIMS Module 2 Entering Incident Reviews www.hseland.ie NIMS Reports, Views and Dashboard Training – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Introduction to Serious Incident Management Team (SIMT) www.hseland.ie An introduction to Children First www.hseland.ie Children First briefing for HSE Line Managers – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ Safeguarding adults at risk of abuse www.hseland.ie National Clinical Guidelines https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/

How to learn more about Safety, Risk and Incident Management

Learn while you work (in-practice development opportunities)

1. Shadow a colleague conducting a risk assessment for your area
2. Review incident trends in your area using NIMS data
3. Lead or take part in an After Action Review
4. Involve staff in regular safety rounds where they identify risks, assess potential hazards and concerns.
5. Take part in a System Review in your area where possible.
6. Shadow a colleague leading an open disclosure meeting.

Read a Policy, Procedure or Guideline

HSE Enterprise Risk Management Policy and Procedures 2023
https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-enterprise-risk-management-policy/

HSE Open Disclosure Policy
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/hse-open-disclosure-full-policy-2019.pdf

HSE Incident Management Framework
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Further Learning

HSE Enterprise Risk Management Website
https://www.hse.ie/eng/about/who/riskmanagement/

QPS Incident Management Website
https://www2.healthservice.hse.ie/organisation/qps-incident-management/

Patient Safety Together
https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

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PLAY VIDEO

Select the page icon to view a transcript of the video

Partnering with People for Team Leaders

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I encourage and lead staff to demonstrate person-centred care as part of their everyday practice.	
I support and lead staff to partner with patients, service users, families and communities to ensure we deliver care in line with their needs and preferences.	
I promote patient involvement in improving the design and delivery of care.	
I use appropriate engagement tools and methods to promote involvement in improving the design and delivery of care.	
I use feedback on patient experiences and services to make recommendations for improvement.	
I help to embed the principles of health literacy and cultural awareness in the organisation's processes.	

What this looks like

I lead my team in partnering with people to design and deliver safer better health care.

How to learn more about Partnering with People

Learn while you work (in-practice development opportunities)

1. Promote staff training that focuses on health literacy. This will help staff communicate more effectively with patients to ensure they understand their diagnoses, treatment options and care instructions.
2. Involve patients and families in the co-design of healthcare services or facilities. Learn from their experiences to create more user-friendly, patient-centred environments.
3. Encourage staff to take part in training sessions on cultural competence to understand how to better partner with patients from diverse cultural and social backgrounds.

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources for partnering with people https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

Complete a learning programme

My health - My voice https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/wpsd-2024/

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

Adult Literacy for Life Programmes
https://www.adultliteracyforlife.ie/aware/lets-talk-about-health-literacy-course/
https://www.adultliteracyforlife.ie/aware/lets-talk-about-literacy-friendly-approach-course/

Further Learning

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/

AHRQ Patient and Family Engagement: https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

HSE National Office for Human Rights and Equality Policy
https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/

QPS Talk-Time Webinars on Patient Partnership
https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Patients for Patient Safety Ireland https://patientsforpatientsafety.ie/

Walk and Talk Improvement Podcasts: The importance of patient partners.
https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality Improvement and Clinical Audit for Team Leaders

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the terms quality improvement and quality assurance and their underlying principles.	
I apply common quality improvement methodologies (e.g. Model for Improvement PDSA, Lean, etc.) and tools to make changes in work processes.	
I engage with patients and colleagues to identify opportunities for planning, improving and maintaining quality and to identify their needs and preferences in defining the quality goal.	
I understand clinical audit processes and conduct or support others to conduct clinical audits.	
I use measurement tools and data in planning, improving and maintaining quality.	
I support and encourage my team in speaking up for quality and patient safety.	
I effectively participate in quality improvement research.	
I apply a project management approach to QI projects.	

What this looks like

I lead my team in planning, improving and maintaining quality in my local area of work.

How to learn more about Quality Improvement and Clinical Audit

Learn while you work (in-practice development opportunities)

1. Lead or take part in conducting a clinical audit for your area.
2. Lead or take part in a quality improvement project.
3. Review and discuss improvement opportunities with your team.
4. Review your area's key performance indicators to identify areas for improvement.
5. Present your own clinical audit and QI findings to colleagues for peer review and seek constructive feedback on how to improve future efforts.

Read a Policy, Procedure or Guideline

Framework for Improving Quality in our Health Service https: https://www.lenus.ie/handle/10147/611719

Quality Improvement Toolkit https://www2.healthservice.hse.ie/organisation/qps-education/quality-improvement-toolkit/

Improvement Knowledge and Skills Guide https://www2.healthservice.hse.ie/organisation/qps-education/knowledge-and-skills-guide/

Clinical Audit – A Practical Guide https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf

Complete a learning programme

Introduction to Quality Improvement www.hseland.ie

Foundation in Quality Improvement www.hseland.ie

Working as a Team for Improvement www.hseland.ie

Fundamentals of Clinical Audit www.hseland.ie

Advanced Clinical Audit – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Reducing common causes of harm – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Delivering Change in Health Services - Complete Guide www.hseland.ie

Further Learning

QPS Improvement Website https://www2.healthservice.hse.ie/organisation/qps-improvement/

National Centre for Clinical Audit Website https://www2.healthservice.hse.ie/organisation/ncca/

Q – (A community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care). https://q.health.org.uk/get-involved/events/

IHI - Institute of Healthcare Improvement https://www.ihi.org/

Communications, Teaming and Systems

Select the Play button to learn about this topic and to find out why it is important in healthcare.

Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

Select the page icon to view a transcript of the video

Ciarán McCullagh
National Ambulance Service

PLAY VIDEO

Select the page icon to view a transcript of the video

Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

PLAY VIDEO

Select the page icon to view a transcript of the video

Communication, Teaming and Systems for Everyone

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I encourage and support effective teaming.	
I use methods to support effective and respectful communication in managing and resolving conflict.	
I use communication tools to support effective and clear communication.	
I understand how applying Human Factors principles can enhance well-being and overall systems performance.	
I ensure we use the reality of the working environment to inform the design and re-design of systems that addresses the gap between ‘work-as-done’ and ‘work-as-imagined’.	
I understand the factors that should be considered in the design of tasks and environments to support safety and apply relevant methods to improve systems and outcomes.	

What this looks like

I lead my team to learn and practice effective communication, teaming and systems factors to improve well-being and performance.

How to learn more about Communication, Teaming and Systems

Learn while you work (in-practice development opportunities)

1. Create opportunities for training sessions that bring together different healthcare professionals to practice working collaboratively and understand each other's roles
2. Lead team huddles/meetings to discuss the day's objectives, patient care plans, patient safety risks and allocate responsibilities.
3. Provide feedback to team members on communication and teaming.
4. Encourage and create opportunities for interdisciplinary team working.
5. Take part in simulation scenarios that mimic real-life clinical situations which promote effective teamwork and role clarity and foster skills like communication and coordination.

Complete a learning programme

Introduction to Human Factors www.hseland.ie

Working as a Team for Improvement www.hseland.ie

Handling Team Conflict www.hseland.ie

Encouraging Team Communication and Collaboration www.hseland.ie

Strategies for Building a Cohesive Team www.hseland.ie

National Healthcare Communication Programme https://www.hse.ie/eng/about/our-health-service/healthcare-communication/

SAFE (Situational Awareness for Everyone) – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

TeamSTEPPS https://www.ahrq.gov/teamstepps-program/index.html

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

The Human Factors Hub https://learn.nes.nhs.scot/21394

Read a Policy, Procedure or Guideline

An Introduction to Human Factors for Healthcare Workers https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf

Health Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

The Health Literacy Place https://www.healthliteracyplace.org.uk/

HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

Further Learning

Irish Human Factors and Ergonomics Society https://ihfes.org/

Clinical Human Factors Group – The Health Foundation https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group

A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19

HSE Leadership, Learning and Talent Management programmes https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/

How to turn a group of strangers into a team: https://www.ted.com/talks/amy_edmondson_how_to_turn_a_group_of_strangers_into_a_team/transcript?subtitle=en

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Sustainability for Team Leaders

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I assess the environmental sustainability of the quality and patient safety initiatives we develop and implement in the organisation.	
I promote the use of healthcare resources in an environmentally aware way.	
I lead staff in finding sustainable ways of improving the quality, safety and delivery of care.	
I support local efforts to promote sustainability and reduce impact of negative impact to the environment.	
I consider and support suggestions from others about making the way we work more sustainable.	
I consider sustainability as part of decision making, for example in procurement decision making.	

What this looks like

I encourage the sustainable use of resources in maintaining quality and safe health care for the long term.

How to learn more about Sustainability

Learn while you work (in-practice development opportunities)

1. Establish and encourage participation in sustainability committees or green teams within the healthcare organisation that promote environmental initiatives and peer learning.
2. Apply principles of sustainability in all settings such as reducing overuse of supplies and adopting reusable medical equipment where appropriate.
3. Encourage team members to attend workshops or seminars which focus on environmental sustainability in healthcare, waste reduction, energy efficiency and eco-friendly practices.
4. Use QI or LEAN methodologies to reduce waste.
5. Consider virtual care and communication where appropriate.

Read a Policy, Procedure or Guideline

HSE Climate Action Strategy
https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Sustainability in quality improvement (SusQI): a case-study in undergraduate medical education
https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-02817-2

Complete a learning programme

RCSI Sustainable Healthcare Online https://www.rcsi.com/online/courses/sustainable-healthcare/course-details

World Health Organisation Online Course https://www.who.int/teams/environment-climate-change-and-health/training

Global Health e-learning https://rise.articulate.com/share/eC-tXqaq7BzR7Kl8N1OGu86Th-gNvArl#/

Email climate.action@hse.ie to enrol on the following e-learning programmes
Waste Reduction
Food Reduction
Water Efficiency for Technical Staff

Carbon Basics – Create an SEAI account to avail of training https://energylink.seai.ie/login

Further Learning

National Health Sustainability Office https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/

17 United Nations Sustainable Development Goals
https://www.un.org/sustainabledevelopment/sustainable-development-goals/

Green Health Care https://greenhealthcare.ie/

Global Health Curriculum for Specialist Medical Training in Ireland https://www.theforum.ie/wp-content/uploads/2023/11/Global-Health-Curriculum-Final-for-Print.pdf

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for Team Leaders

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I seek to learn from quality and safety excellence in healthcare and from other sectors.	
I can assess a workplace culture of quality and patient safety and determine the areas of strength and weakness.	
I champion a quality and safety culture environment in my organisation.	
I ensure my words and actions model and uphold organisational values to support quality, safe care.	
I receive and act on quality and safety concerns and use the information for learning and improvement.	

What this looks like

I lead my team in promoting a quality and patient safety culture.

How to learn more about Quality and Patient Safety Culture

Learn while you work (in-practice development opportunities)

1. Make Quality and Patient Safety a standing item on your team meeting agenda.
2. Participate in your organisation's Quality & Patient Safety Committee.
3. Review data such as patient feedback, audit results investigation and evaluation reports to identify quality and patient safety issues and areas for improvement.
4. Lead or take part in a safety huddle or safety pause.
5. Lead or take part in a quality improvement initiative.
6. Lead or take part in a clinical audit for your area.

Read a Policy, Procedure or Guideline

Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955

National Standards for Safer, Better Healthcare – HIQA https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

HSE 'Just Culture' Information https://www2.healthservice.hse.ie/organisation/qps-incident-management/just-culture/

Improving patient safety culture – a practical guide https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/

Developing Organisational Culture – Guide for the Health Service https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

Complete a learning programme

Foundation in Quality Improvement www.hseland.ie

Situational Awareness for Everyone (SAFE) Collaborative – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Further Learning

Patient Safety Together: learning, sharing and improving website https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Ways to connect with Quality and Patient Safety – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

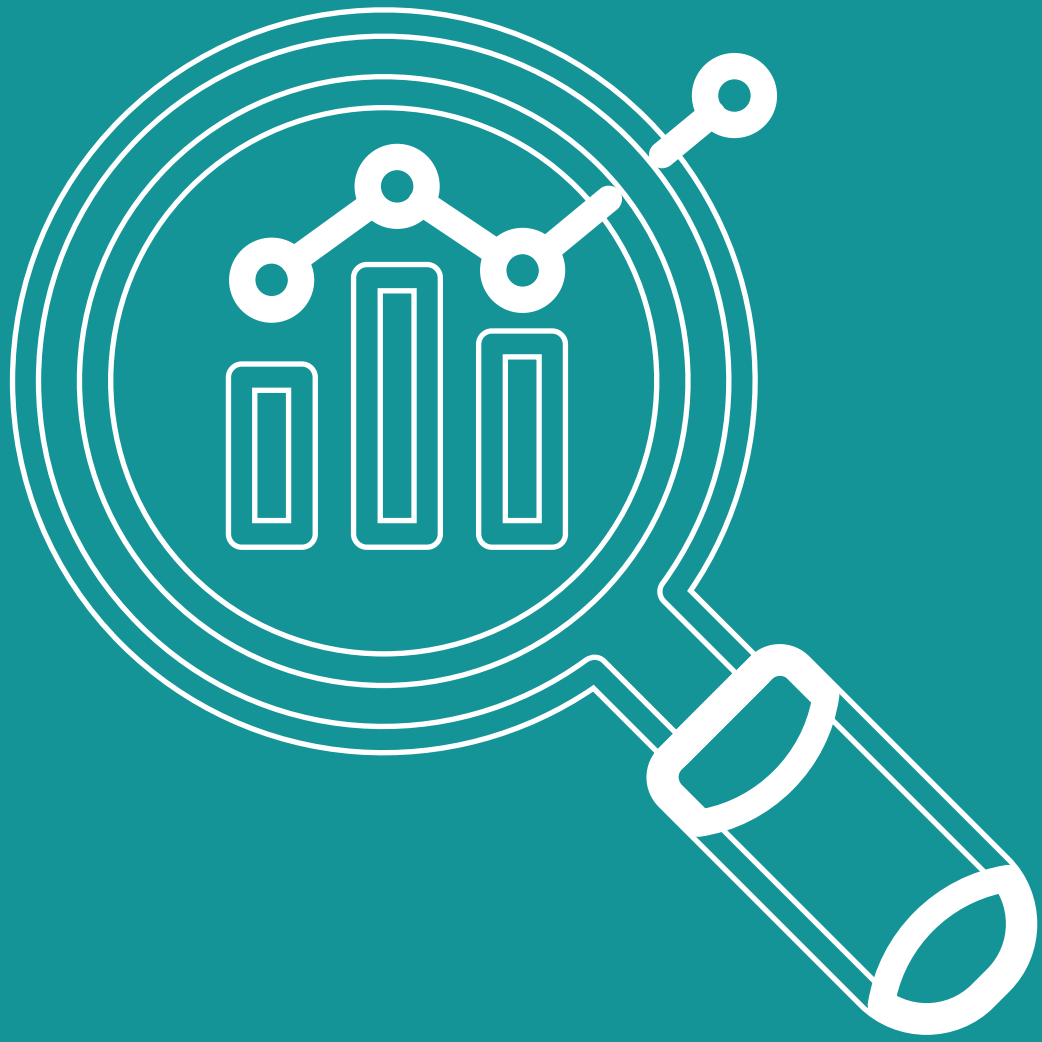
AHRQ Surveys on Patient Safety Culture https://www.ahrq.gov/topics/surveys-patient-safety-culture.html

The Health Foundation: The Measuring and Monitoring of Safety https://www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf

Safety Culture (NHS) https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture/

QPS Roles and Champions

Staff who work in quality, patient safety, clinical audit, risk, leadership and other aspects of QPS. QPS Champions may or may not be working in QPS but have a particular interest in QPS and want to learn more and do more.



PREV

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Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

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PLAY VIDEO

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Safety, Risk and Incident Management for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand my organisation's approach to risk and my role and responsibilities including reporting and reviewing escalated risks and providing assurance on controls and accountability for actions.	
I assess risks based on their likelihood and impact.	
I value and promote person-centred care in risk decision making.	
I align my organisation's strategic objectives to operational plans and service developments and assess any potential risks to achieving same.	
I implement and ensure compliance with safety, risk and incident management policies and procedures.	
I involve patients and families in discussions about safety incidents and their reviews.	
I facilitate Open Disclosure in line with the specific needs of the patient or their relevant person where indicated.	
I review incident reports, incident trends and patient feedback regularly to improve quality and safety of care.	
I use appropriate methods to understand system failures and implement strategies to improve safety for everyone.	
I am aware of my responsibilities in relation to safeguarding and follow the policies and procedures in my organisation.	

What this looks like

I lead, advise and support others to effectively manage safety, risks and incidents.

How to learn more about Safety, Risk and Incident Management

Complete a learning programme
Enterprise Risk Management – An Introduction https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/2023-hse-enterprise-risk-management-training/module-1-erm-introduction.html The Fundamentals of Enterprise Risk Management www.hseland.ie Using the HSE Excel Risk Register www.hseland.ie HSE Excel Risk Register 'How-to' video https://youtu.be/W4mEGisgwDw
Module 1 – Communicating Effectively through Open Disclosure www.hseland.ie Module 2 – Open Disclosure - Applying Principles to Practice www.hseland.ie Open Disclosure Face to Face Skills Training – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ The Patient Safety Act (2023) www.hseland.ie The role of the Designated Person in Incident Management and Open Disclosure www.hseland.ie
NIMS Module 1 Training for Incident Entry www.hseland.ie NIMS Module 2 Entering Incident Reviews www.hseland.ie NIMS Reports, Views and Dashboard Training – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Introduction to Serious Incident Management Team (SIMT) www.hseland.ie An introduction to Children First www.hseland.ie Children First briefing for HSE Line Managers – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ Safeguarding adults at risk of abuse www.hseland.ie National Clinical Guidelines https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/

How to learn more about Safety, Risk and Incident Management

Learn while you work (in-practice development opportunities)

1. Shadow a colleague conducting a risk assessment.
2. Review incident trends in your area using NIMS data.
3. Shadow a colleague leading an After Action Review.
4. Shadow a colleague leading a System Review where possible.
5. Shadow a colleague leading an open disclosure meeting.
6. Take part in a Serious Incident Management Team (SIMT) meeting.
7. Involve staff in regular safety rounds where they identify risks, assess potential hazards and discuss safety protocols.

Further Learning

HSE Enterprise Risk Management Website
https://www.hse.ie/eng/about/who/riskmanagement/

Open Disclosure Webinar Programme https://www2.healthservice.hse.ie/organisation/qps-incident-management/open-disclosure/webinars/

QPS Incident Management Website
https://www2.healthservice.hse.ie/organisation/qps-incident-management/

Patient Safety Community – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Patient Safety Together
https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

State Claim Agency https://stateclaims.ie/

Read a Policy, Procedure or Guideline

HSE Enterprise Risk Management Policy and Procedures 2023
https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-enterprise-risk-management-policy/

HSE Open Disclosure Policy https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/hse-open-disclosure-full-policy-2019.pdf

HSE Incident Management Framework
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

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Select the page icon to view a transcript of the video

Partnering with People for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I support staff to demonstrate person-centred care as part of their everyday practice.	
I support staff to partner with patients, service users, families and communities to ensure care is delivered in line with their needs and preferences.	
I promote patient involvement in improving the design and delivery of care.	
I use appropriate engagement tools and methods to promote involvement in improving the design and delivery of care.	
I use feedback on patient experiences and services to make recommendations for improvement.	
I help to embed the principles of health literacy and cultural awareness in the organisation's processes.	
I involve patients in co-designing improvements in health services in way that acknowledges and values diversity.	

What this looks like

I champion and promote partnering with people to design and deliver safer and quality health care.

How to learn more about Partnering with People

Learn while you work (in-practice development opportunities)

1. Coordinate and engage in training that focuses on health literacy, helping staff communicate more effectively with patients to ensure they understand their diagnoses, treatment options, and care instructions.
2. Involve patients and families in the co-design of healthcare services or facilities, learning from their experiences to create more user-friendly, patient-centred environments.
3. Create opportunities for staff to develop cultural awareness to help them to understand how to better partner with patients from diverse cultural and social backgrounds

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources for partnering with people https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

Complete a learning programme

My health - My voice https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/wpsd-2024/

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

Adult Literacy for Life Programmes
https://www.adultliteracyforlife.ie/aware/lets-talk-about-health-literacy-course/
https://www.adultliteracyforlife.ie/aware/lets-talk-about-literacy-friendly-approach-course/

Further Learning

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/

AHRQ Patient and Family Engagement https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

HSE National Office for Human Rights and Equality Policy
https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/

QPS Talk-Time Webinars on Patient Partnership
https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Patients for Patient Safety Ireland https://patientsforpatientsafety.ie/

Walk and Talk Improvement Podcasts: The importance of patient partners.
https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality Improvement and Clinical Audit for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the key components of a quality management system across an organisation.	
I partner with patients and colleagues in co-producing quality goals.	
I can mentor/coach others in the use of quality improvement methodologies (e.g. Model for Improvement PDSA, Lean, etc.) and tools to change work processes.	
I use measurement tools and data including those relating to variation, measurement over time and the display of information to influence change.	
I can combine clinical audit and quality improvement to achieve quality goals.	
I support a learning environment and a culture of learning and quality improvement within my area.	
I apply evaluation techniques to measure the cost impact of quality improvements.	
I can effectively lead and participate in quality improvement research.	
I apply a project management approach to quality improvement projects.	

What this looks like

I lead by planning, improving and maintaining quality within my role or as a champion of quality and patient safety.

How to learn more about Quality Improvement and Clinical Audit

Complete a learning programme
Introduction to Quality Improvement www.hseland.ie
Foundation in Quality Improvement www.hseland.ie
Working as a Team for Improvement www.hseland.ie
Fundamentals of Clinical Audit www.hseland.ie
Advanced Clinical Audit – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Reducing common causes of harm – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Quality Coach Development Programme https://q.health.org.uk/resource/quality-coach-development-programme/
Data for Decision Making – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Data for Decision Making: Using the Toolkit – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Introduction to producing SPC Charts – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Delivering Change in Health Services - Complete Guide www.hseland.ie
SPARK Design Thinking Workshop https://healthservice.hse.ie/about-us/onmsd/onmsd-blog/hse-spark-innovation-programme.html
Teamstepps https://www.ahrq.gov/teamstepps-program/training/index.html

How to learn more about Quality Improvement and Clinical Audit

Learn while you work (in-practice development opportunities)

1. Lead or take part in conducting a clinical audit for your area.
2. Lead/Coach or take part in a quality improvement project.
3. Identify areas for improvement in your organisation by reviewing data such as patient feedback, KPIs, audit results and inspection/evaluation reports.
4. Take part in a Quality & Safety Walk-round.
5. Lead or take part in your organisation's Quality & Patient Safety Committee.
6. Present your own clinical audit and QI findings to colleagues for peer review.
7. Seek constructive feedback on how to improve future efforts.

Read a Policy, Procedure or Guideline

Framework for Improving Quality in our Health Service
https://www.lenus.ie/handle/10147/611719

Quality Improvement Toolkit https://www2.healthservice.hse.ie/organisation/qps-education/quality-improvement-toolkit/

Improvement Knowledge and Skills Guide
https://www2.healthservice.hse.ie/organisation/qps-education/knowledge-and-skills-guide/

Clinical Audit – A Practical Guide
https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf

Further Learning

QPS Improvement Website https://www2.healthservice.hse.ie/organisation/qps-improvement/

National Centre for Clinical Audit Website https://www2.healthservice.hse.ie/organisation/ncca/

Q – (A community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care).
https://q.health.org.uk/get-involved/events/

Certificate in Quality Improvement Leadership in Healthcare – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

IHI - Institute of Healthcare Improvement https://www.ihi.org/

Communications, Teaming and Systems

Select the Play button to learn about this topic and to find out why it is important in healthcare.

Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

Select the page icon to view a transcript of the video

Ciarán McCullagh
National Ambulance Service

PLAY VIDEO

Select the page icon to view a transcript of the video

Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

PLAY VIDEO

Select the page icon to view a transcript of the video

Communication, Teaming and Systems for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I encourage and support effective teaming.	
I use methods to support effective and respectful communication in managing and resolving conflict.	
I use communication tools to support effective and clear communication.	
I understand how applying Human Factors principles can enhance well-being and overall systems performance.	
I ensure we use the reality of the working environment to inform the design and re-design of systems that addresses the gap between ‘work-as-done’ and ‘work-as-imagined’.	
I understand the factors that should be considered in the design of tasks and environments to support safety and apply relevant methods to improve systems and outcomes.	

What this looks like

I lead, advise and support people to work in teams to design and redesign systems and processes that meets people’s needs.

How to learn more about Communication, Teaming and Systems

Learn while you work (in-practice development opportunities)

1. Create opportunities for training sessions that bring together different healthcare professionals to practice working collaboratively and understand each other's roles
2. Take part in team huddles/meetings to discuss the day's objectives, patient care plans, patient safety risks and allocate responsibilities.
3. Encourage and create opportunities for interdisciplinary team working.
4. Take part in simulation scenarios that mimic real-life clinical situations which promote effective teamwork and role clarity and foster skills like communication and coordination.

Read a Policy, Procedure or Guideline

An Introduction to Human Factors for Healthcare Workers https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf

Health Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

The Health Literacy Place https://www.healthliteracyplace.org.uk/

HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

Complete a learning programme

Introduction to Human Factors www.hseland.ie

Working as a Team for Improvement www.hseland.ie

Handling Team Conflict www.hseland.ie

Encouraging Team Communication and Collaboration www.hseland.ie

Strategies for Building a Cohesive Team www.hseland.ie

National Healthcare Communication Programme https://www.hse.ie/eng/about/our-health-service/healthcare-communication/

SAFE (Situational Awareness for Everyone) – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

TeamSTEPPS https://www.ahrq.gov/teamstepps-program/index.html

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

The Human Factors Hub https://learn.nes.nhs.scot/21394

Further Learning

Irish Human Factors and Ergonomics Society https://ihfes.org/

Clinical Human Factors Group – The Health Foundation https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group

A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19

HSE Leadership, Learning and Talent Management programmes https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/

How to turn a group of strangers into a team: https://www.ted.com/talks/amy_edmondson_how_to_turn_a_group_of_strangers_into_a_team/transcript?subtitle=en

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Sustainability for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I can assess the environmental sustainability of the quality and patient safety initiatives we develop and implement in the organisation.	
I promote the use of healthcare resources in an environmentally aware way.	
I support staff in finding sustainable ways of improving the quality, safety and delivery of care.	
I support local efforts to promote sustainability and reduce impact of negative impact to the environment.	
I consider and support suggestions from others about making the way we work more sustainable.	
I consider sustainability as part of decision making for example in procurement decision making.	

What this looks like

I assess the sustainable use of resources in maintaining quality and safe healthcare for the long term.

How to learn more about Sustainability

Learn while you work (in-practice development opportunities)

1. Establish (and encourage others to take part) in sustainability committees or green teams in your area that promote environmental initiatives and peer learning.
2. Apply the principles of sustainability in in your area including clinical settings, such as reducing overuse of supplies and adopting reusable medical equipment where appropriate.
3. Encourage team members to attend workshops or seminars on environmental sustainability in healthcare, focusing on waste reduction, energy efficiency and eco-friendly practices.
4. Use QI or LEAN methodologies to reduce waste.
5. Consider virtual care and communication where appropriate.

Read a Policy, Procedure or Guideline

HSE Climate Action Strategy
https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Sustainability in quality improvement (SusQI): a case-study in undergraduate medical education
https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-02817-2

Complete a learning programme

RCSI Sustainable Healthcare Online https://www.rcsi.com/online/courses/sustainable-healthcare/course-details

World Health Organisation Online Course https://www.who.int/teams/environment-climate-change-and-health/training

Global Health e-learning https://rise.articulate.com/share/eC-tXqaq7BzR7Kl8N1OGu86Th-gNvArl#/

Email climate.action@hse.ie to enrol on the following e-learning programmes
Waste Reduction
Food Reduction
Water Efficiency for Technical Staff

Carbon Basics – Create an SEAI account to avail of training
https://energylink.seai.ie/login

Further Learning

National Health Sustainability Office https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/

17 United Nations Sustainable Development Goals
https://www.un.org/sustainabledevelopment/sustainable-development-goals/

Green Health Care https://greenhealthcare.ie/

Global Health Curriculum for Specialist Medical Training in Ireland https://www.theforum.ie/wp-content/uploads/2023/11/Global-Health-Curriculum-Final-for-Print.pdf

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for QPS Roles & Champions

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I seek to learn from quality and safety excellence in healthcare and from other sectors.	
I can assess a workplace culture of quality and patient safety and determine the areas of strength and weakness.	
I champion a quality and safety environment within my work environment.	
I receive and act on quality and safety concerns and use the information for learning and improvement.	
I review quality and safety culture measurement data.	
I ensure quality and safety are routinely considered part of my organisation's core governance structures and procedures.	

What this looks like

I promote a culture of quality and patient safety culture as an integral part of my role.

How to learn more about Quality and Patient Safety Culture

Complete a learning programme
Foundation in Quality Improvement www.hseland.ie
Advanced Clinical Audit – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Practical Tutorial in Clinical Audit for Healthcare Professionals – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Schwartz Rounds – https://www.pointofcarefoundation.org.uk/our-programmes/schwartz-rounds/

Read a Policy, Procedure or Guideline
Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955
National Standards for Safer, Better Healthcare – HIQA https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare
HSE 'Just Culture' Information https://www2.healthservice.hse.ie/organisation/qps-incident-management/just-culture/
Improving patient safety culture – a practical guide https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/
Developing Organisational Culture – Guide for the Health Service https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

How to learn more about Quality and Patient Safety Culture

Learn while you work (in-practice development opportunities)

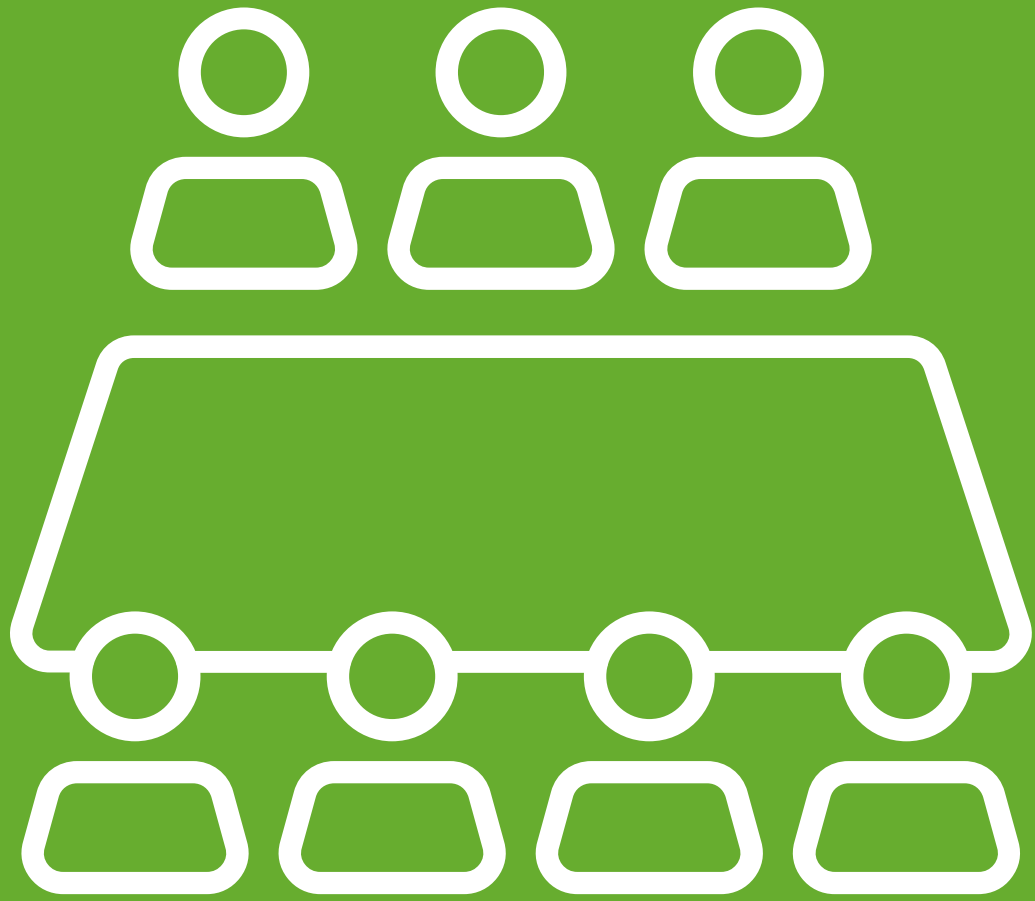
1. Lead or take part in your organisation's Quality & Patient Safety Committee.
2. Review data such as patient feedback, KPIs, audit results, investigation and evaluation reports to identify quality and patient safety issues and areas for improvement.
3. Feedback data to teams to support them in identifying areas for improvement.
4. Lead or take part in a safety huddle or safety pause.
5. Lead or take part in a Schwartz round

Further Learning

Patient Safety Together: learning, sharing and improving website https://www2.healthservice.hse.ie/organisation/nqpsd/pst/
Ways to connect with Quality and Patient Safety – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Health Information and Quality Authority Website https://www.hiqa.ie/
AHRQ Surveys on Patient Safety Culture https://www.ahrq.gov/topics/surveys-patient-safety-culture.html
The Health Foundation: The Measuring and Monitoring of Safety https://www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf
Safety Culture (NHS) https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture/

Senior Leaders and Board Members

Senior leaders and board members who set the strategic quality and patient safety goals. They govern and lead the commitment to improving quality and patient safety.



PREV

NEXT

STEP 2

Select the topic you would like to explore

These are the key topic areas for developing quality and patient safety competence. All topics are of equal importance. The number of competencies and range of resources may vary for each.

This Navigator is a dynamic resource. We will add further competencies and resources as areas develop, for example ‘sustainability’.

Senior Leaders and Board Members

Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Safety, Risk and Incident Management for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand that risk-informed decision-making aligns risks with achieving objectives and strategic planning.	
I understand my organisation's approach to risk and my role and responsibilities including reporting and reviewing escalated risks and providing assurance on controls and accountability for actions.	
In my role, I assess risks based on their likelihood and impact.	
I value and promote person-centred care in risk decision making.	
I align my organisation's strategic objectives to operational plans and service developments and assess any potential risks to achieving same.	
I implement and ensure compliance with safety, risk and incident management policies and procedures.	
I involve patients and families in discussions about safety incidents and their reviews.	
I facilitate Open Disclosure in line with the specific needs of the patient or their relevant person where indicated.	
I review incident reports, incident trends and patient feedback regularly to improve quality and safety of care.	
I use appropriate methods to understand system failures and implement strategies to improve safety for everyone.	
I am aware of my responsibilities in relation to safeguarding and follow the policies and procedures in my organisation.	

What this looks like

I enable a culture of accountability and compliance, actively prioritising and supporting safety, risk and incident management across all levels of the organisation.

How to learn more about Safety, Risk and Incident Management

Complete a learning programme
Enterprise Risk Management – An Introduction https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/2023-hse-enterprise-risk-management-training/module-1-erm-introduction.html
Module 1 – Communicating Effectively through Open Disclosure www.hseland.ie Module 2 – Open Disclosure - Applying Principles to Practice www.hseland.ie The Patient Safety Act (2023) www.hseland.ie The role of the Designated Person in Incident Management and Open Disclosure www.hseland.ie
Introduction to Serious Incident Management Team (SIMT) www.hseland.ie SIMT in Practice for Senior Managers – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ Systems Analysis Review Training – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
An introduction to Children First www.hseland.ie Children First briefing for HSE Line Managers – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/ Safeguarding adults at risk of abuse. www.hseland.ie

Further Learning
HSE Enterprise Risk Management Website https://www.hse.ie/eng/about/who/riskmanagement/
Open Disclosure Webinar Programme https://www2.healthservice.hse.ie/organisation/qps-incident-management/open-disclosure/webinars/
QPS Incident Management Website https://www2.healthservice.hse.ie/organisation/qps-incident-management/
Patient Safety Community – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Patient Safety Together https://www2.healthservice.hse.ie/organisation/nqpsd/pst/
State Claim Agency https://stateclaims.ie/

How to learn more about Safety, Risk and Incident Management

Learn while you work (in-practice development opportunities)

1. Shadow a colleague conducting a risk assessment for your area.
2. Review incident trends in your area using NIMS data.
3. Shadow a colleague leading an After Action Review.
4. Shadow a colleague leading a Systems Review.
5. Shadow a colleague leading an open disclosure meeting.
6. Take part in a Serious Incident Management Team (SIMT) meeting.
7. Involve staff in regular safety rounds where they identify risks, assess potential hazards, and discuss safety protocols in their departments.

Read a Policy, Procedure or Guideline

HSE Enterprise Risk Management Policy and Procedures 2023
https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-enterprise-risk-management-policy/

HSE Open Disclosure Policy https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/hse-open-disclosure-full-policy-2019.pdf

HSE Incident Management Framework
https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Code of Practice for Government and State bodies
https://www.gov.ie/en/publication/0918ef-code-of-practice-for-the-governance-of-state-bodies/

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Partnering with People for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I ensure that patients are involved in co-designing improvements in health services in way that acknowledges and values diversity.	
I ensure the principles of health literacy and cultural awareness are embedded in the organisation's processes.	
I support and advance the patient partnership agenda through strategy, policies, procedures, and action plans.	
I ensure my organisation integrates the views, experiences and perspectives of patients into the design, delivery and evaluation of healthcare services in way that acknowledges and values diversity.	

What this looks like

I enable partnering with people to design and deliver quality safe are across all levels of the organisation.

How to learn more about Partnering with People

Learn while you work (in-practice development opportunities)

1. Support staff with training to help them involve patients and their families to create care plans, ensure they have a voice in the treatment process and to foster shared decision-making.
2. Promote and encourage strategies that involve patients and families in the co-design of healthcare services or facilities, learning from their experiences to create more user-friendly, patient-centred environments.
3. Work with patient advocacy groups to find ways to support collaborative approaches to designing effective, safe care that meets patient needs.

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources for partnering with people https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

Better Public Services: Service Design Resources https://www.gov.ie/en/publication/4ac9a-service-design/

Complete a learning programme

My health - My voice https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/wpsd-2024/

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

Adult Literacy for Life Programmes
https://www.adultliteracyforlife.ie/aware/lets-talk-about-health-literacy-course/
https://www.adultliteracyforlife.ie/aware/lets-talk-about-literacy-friendly-approach-course/

Further Learning

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/

AHRQ Patient and Family Engagement: https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

QPS Talk-Time Webinars on Patient Partnership
https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Patients for Patient Safety Ireland https://patientsforpatientsafety.ie/

Walk and Talk Improvement Podcasts: The importance of patient partners.
https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality Improvement and Clinical Audit for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I recognise the importance of partnering with people who use health services and with staff in undertaking quality improvement.	
I can describe the role of organisational values and vision in supporting and enabling a culture of quality and patient safety.	
I understand the importance and support the alignment of national, regional and local quality and safety goals to deliver safer, quality care.	
I support and recognise the importance of giving staff permission and time for quality improvement.	
I demonstrate leadership commitment to a culture of continuous learning and quality improvement.	
I recognise the importance of partnering with people who use health services and with staff in undertaking quality improvement.	
I support openness and transparency as part of my role.	
I can effectively promote and support quality improvement research.	

What this looks like

I support and contribute to planning, improving and maintaining quality at a regional, national or Board level.

How to learn more about Quality Improvement and Clinical Audit

Learn while you work (in-practice development opportunities)

1. Identify areas for improvement in your organisation by reviewing data such as patient feedback, KPIs, audit results and inspection/evaluation reports.
2. Sponsor a quality improvement project.
3. Take part in a Quality & Safety Walk-round.
4. Take part in your organisation's Quality & Patient Safety Committee meetings.

Read a Policy, Procedure or Guideline

Framework for Improving Quality in our Health Service
https://www.lenus.ie/handle/10147/611719

Clinical Audit – A Practical Guide
https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf

Complete a learning programme

Data for Decision Making – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Delivering Change in Health Services - Complete Guide www.hseland.ie

Post Graduate Certificate in Quality Improvement Leadership in Healthcare – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Further Learning

QPS Improvement Website https://www2.healthservice.hse.ie/organisation/qps-improvement/

National Centre for Clinical Audit Website https://www2.healthservice.hse.ie/organisation/ncca/

Q – (A community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care).
https://q.health.org.uk/get-involved/events/

Institute of Healthcare Improvement https://www.ihi.org/resources/tools

Oxford Professional Practice: Handbook of Quality Improvement in Healthcare
https://global.oup.com/academic/product/oxford-professional-practice-handbook-of-patient-safety-9780192846877?cc=us&lang=en&

Communications, Teaming and Systems

Select the Play button to learn about this topic and to find out why it is important in healthcare.

Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

Select the page icon to view a transcript of the video

Ciarán McCullagh
National Ambulance Service

PLAY VIDEO

Select the page icon to view a transcript of the video

Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

PLAY VIDEO

Select the page icon to view a transcript of the video

Communication, Teaming and Systems for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand how the application of Human Factors principles can enhance well-being and overall systems performance.	
I encourage and support effective teaming.	
I use methods to support effective and respectful communication in managing and resolving conflict.	
I ensure adequate training and resources are available to staff to support effective communication in my organisation.	

What this looks like

I enable to staff to learn and practice effective communication, teaming and systems factors to improve well-being and performance across all levels of the organisation.

How to learn more about Communication, Teaming and Systems

Learn while you work (in-practice development opportunities)

1. Observe (and facilitate staff to take part in) simulation scenarios that mimic real-life clinical situations which promote effective teamwork and role clarity and foster skills like communication and coordination.
2. Encourage and create opportunities for interdisciplinary team working.
3. Advocate the importance of daily huddles and team meetings with a focus on quality and patient safety.

Read a Policy, Procedure or Guideline

An Introduction to Human Factors for Healthcare Workers https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf

Health Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

The Health Literacy Place https://www.healthliteracyplace.org.uk/

HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

Complete a learning programme

Introduction to Human Factors www.hseland.ie

Working as a Team for Improvement www.hseland.ie

National Healthcare Communication Programme https://www.hse.ie/eng/about/our-health-service/healthcare-communication/

SAFE (Situational Awareness for Everyone) – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

TeamSTEPPS https://www.ahrq.gov/teamstepps-program/index.html

Leading multi-cultural teams https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/leading-multi-cultural-teams/

Further Learning

Irish Human Factors and Ergonomics Society https://ihfes.org/

Clinical Human Factors Group – The Health Foundation https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group

HSE National Simulation Office https://www.hse.ie/eng/about/who/national-simulation-office/

A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19

HSE Leadership, Learning and Talent Management programmes https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/

How to turn a group of strangers into a team: https://www.ted.com/talks/amy_edmondson_how_to_turn_a_group_of_strangers_into_a_team/transcript?subtitle=en

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Sustainability for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I support and advocate for my organisation to prioritise environmental sustainability as part of quality and safety activities.	
I support the service changes required to improve the resilience towards climate change and impact.	
I foster a culture of sustainability and actively promote sustainability initiatives across the organisation.	
I promote awareness, education and training programmes to increase staff understanding of sustainability in healthcare.	
I consider and support suggestions from others about making the way we work more sustainable.	
I consider sustainability as part of organisational decision making, for example procurement decision making.	
I support and share information about the impact of sustainability initiatives in this organisation.	

What this looks like

I prioritse the sustainable use of resources in organisations to maintain quality and safe healthcare for the long term.

How to learn more about Sustainability

Learn while you work (in-practice development opportunities)

1. Engage with sustainability committees or green teams in your organisation that promote environmental initiatives and peer learning.
2. Apply the principles of sustainability in your organisation such as encouraging a reduction in the overuse of supplies and adopting reusable medical equipment where appropriate.
3. Promote a culture of considering sustainability in all decisions and organisational strategies relevant to quality and safety.
4. Promote workshops or seminars on environmental sustainability in healthcare, focusing on waste reduction, energy efficiency and eco-friendly practices at all levels of the organisation.
5. Use QI or LEAN methodologies to reduce waste.
6. Consider virtual care and communication where appropriate.

Read a Policy, Procedure or Guideline

HSE Climate Action Strategy
https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Sustainability in quality improvement (SusQI): a case-study in undergraduate medical education
https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-02817-2

Complete a learning programme

RCSI Sustainable Healthcare Online https://www.rcsi.com/online/courses/sustainable-healthcare/course-details

World Health Organisation Online Course https://www.who.int/teams/environment-climate-change-and-health/training

Global Health e-learning https://rise.articulate.com/share/eC-tXqaq7BzR7Kl8N1OGu86Th-gNvArl#/

Email climate.action@hse.ie to enrol on the following e-learning programmes
Waste Reduction
Food Reduction
Water Efficiency for Technical Staff

Carbon Basics – Create an SEAI account to avail of training
https://energylink.seai.ie/login

Further Learning

National Health Sustainability Office https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/

17 United Nations Sustainable Development Goals
https://www.un.org/sustainabledevelopment/sustainable-development-goals/

Centre for sustainable healthcare https://sustainablehealthcare.org.uk/

Green Health Care https://greenhealthcare.ie/

Global Health Curriculum for Specialist Medical Training in Ireland https://www.theforum.ie/wp-content/uploads/2023/11/Global-Health-Curriculum-Final-for-Print.pdf

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for Senior Managers & Board Members

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I ensure we routinely consider quality and safety as part of core organisational/governance structures.	
I ensure we have structures and processes in place to support the quality and safety vision for the organisation.	
I ensure the organisational strategic and operational plan clearly articulates the quality and safety vision for the organisation.	

What this looks like

I lead by promoting a culture of quality and patient safety within my scope that influences healthcare practices and policies at broader levels.

How to learn more about Quality and Patient Safety Culture

Learn while you work (in-practice development opportunities)

1. Ensure Quality and Patient Safety is a standing item on your management team agenda.
2. Identify areas for improvement in your organisation by reviewing data such as patient feedback, KPIs, audit results and inspection/evaluation reports.
3. Participate in a Quality & Safety Walk-round.
4. Participate in your organisation's Quality & Patient Safety Committee meetings.

Read a Policy, Procedure or Guideline

Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955

National Standards for Safer, Better Healthcare – HIQA
https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

HSE 'Just Culture' Information
https://www2.healthservice.hse.ie/organisation/qps-incident-management/just-culture/

Improving patient safety culture – a practical guide: https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/

Developing Organisational Culture – Guide for the Health Service
https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

Complete a learning programme

Schwartz Rounds – https://www.pointofcarefoundation.org.uk/our-programmes/schwartz-rounds/

Further Learning

Patient Safety Together: learning, sharing and improving website
https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Ways to connect with Quality and Patient Safety – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/

Safety Culture (NHS)
https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture/

Patients and Patient Partners

Patients or those who advocate on behalf of patients. They engage with quality and patient safety work in partnership with healthcare organisations.

PREV

NEXT

STEP 2

Select the topic you would like to explore

These are the key topic areas for developing quality and patient safety competence. All topics are of equal importance. The number of competencies and range of resources may vary for each.

This Navigator is a dynamic resource. We will add further competencies and resources as areas develop, for example ‘sustainability’.

Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Safety, Risk and Incident Management for Patient/Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand it is important to tell my healthcare provider about previous treatments or surgeries I have had.	
I understand it is important to tell my healthcare provider about any allergies I have and my current medication and treatment.	
I understand it is important to tell my healthcare provider about any health conditions that run in my family.	
I understand it is important to know the risks and benefits.	
I know that I can raise my concerns about any aspects of quality and safety with my healthcare provider, organisation or agency with the support of patient advocates as needed.	
I know my rights and my role as part of the Incident Management and Open Disclosure process.	
I know how to report safeguarding concerns to my healthcare provider.	

What this looks like

I play an active role in helping to ensure safe care by communicating about my care and any concerns I may have.

How to learn more about Safety, Risk and Incident Management

Read a Policy, Procedure or Guideline
HSE Enterprise Risk Management Policy and Procedures 2023 https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-enterprise-risk-management-policy/
HSE Open Disclosure Policy https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/hse-open-disclosure-full-policy-2019.pdf
HSE Incident Management Framework https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Resources to support you
Module 1 – Communicating Effectively through Open Disclosure www.hseland.ie Module 2 – Open Disclosure - Applying Principles to Practice www.hseland.ie The Patient Safety Act (2023) www.hseland.ie The role of the Designated Person in Incident Management and Open Disclosure www.hseland.ie
Enterprise Risk Management – An Introduction https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/2023-hse-enterprise-risk-management-training/module-1-erm-introduction.html
Safeguarding adults at risk of abuse. www.hseland.ie An introduction to Children First www.hseland.ie
HSE Enterprise Risk Management Website https://www.hse.ie/eng/about/who/riskmanagement/
QPS Incident Management Website https://www2.healthservice.hse.ie/organisation/qps-incident-management/
Patient Safety Community – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Patient Safety Together https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Partnering with People for Patients

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I know I have the right to quality, safe care and to share my concerns if I feel unsafe.	
I know I have the right to be involved in choosing my own care and treatment and to express my needs, preferences and values.	
When I am interacting with someone, I am respectful, considerate and communicate openly.	
I understand the value of people working together to improve healthcare services	
I know I have the right to ask questions about my care.	
I can choose to share my experience in different ways to improve healthcare service.	

What this looks like

I partner with health care staff to support the design and delivery of safer, quality health care.

Parting with People for Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the concepts and values value of person-centred care.	
I discuss feedback and ideas from patients and staff when working to improve services.	
I encourage people who deliver and use healthcare services to ask questions, share feedback and ideas for improvement.	
I recognise the value and importance of people working together to improve healthcare services.	
When I am interacting with someone, I am respectful, considerate and communicate openly.	
I understand the importance of making health services equal and accessible for all in a way that acknowledges and values diversity.	
I aim to enhance the participation of vulnerable and excluded groups in health service design, planning and evaluation.	
I encourage staff to demonstrate person-centred care as part of their everyday practice.	
I promote patient and service user involvement in improving the design and delivery of care.	
I use engagement tools and methods to promote involvement in improving the design and delivery of care.	
I use feedback on patient experiences and services to make recommendations for improvement.	
I help to embed the principles of health literacy and cultural awareness in the organisation's processes.	
I ensure that patients/service users and staff are involved in co-designing improvements in health services in way that acknowledges and values diversity.	
I support and advance the patient partnership agenda through strategy, policies, procedures, and action plans.	

What this looks like

I partner with health care staff to support the design and delivery of safer, quality health care.

How to learn more about Partnering with People

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources to support you

Adult Literacy for Life Programmes
https://www.adultliteracyforlife.ie/aware/lets-talk-about-health-literacy-course/
https://www.adultliteracyforlife.ie/aware/lets-talk-about-literacy-friendly-approach-course/

My health - My voice https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/wpsd-2024/

My Medicines list www.safermeds.ie

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

AHRQ Patient and Family Engagement: https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide
https://www.hse.ie/eng/staff/resources/changeguide/

Patients for Patient Safety Ireland, advocacy group collaborating to promote patient safety – www.patientsforpatientsafety.ie

QPS Talk-Time Webinars on Patient Partnership
https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Walk and Talk Improvement Podcasts: The importance of patient partners.
https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality Improvement and Clinical Audit for Patient/Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand I have an important role in providing feedback and contributing to quality improvement.	
I help to identify patient needs and preferences and understand how they can be used in defining the quality goals.	
I can take part in co-production/co-design processes for quality improvement.	
I can take part in quality improvement research.	

What this looks like

I contribute to planning, improving and maintaining quality as a patient/patient partner.

How to learn more about Quality Improvement and Clinical Audit

Read a Policy, Procedure or Guideline
Framework for Improving Quality in our Health Service https://www.lenus.ie/handle/10147/611719
Quality Improvement Toolkit https://www2.healthservice.hse.ie/organisation/qps-education/quality-improvement-toolkit/
Improvement Knowledge and Skills Guide https://www2.healthservice.hse.ie/organisation/qps-education/knowledge-and-skills-guide/
Clinical Audit – A Practical Guide https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf

Resources to support you
Introduction to Quality Improvement www.hseland.ie
Foundation in Quality Improvement www.hseland.ie
Working as a Team for Improvement www.hseland.ie
Fundamentals of Clinical Audit www.hseland.ie
QPS Improvement Website https://www2.healthservice.hse.ie/organisation/qps-improvement/
National Centre for Clinical Audit Website https://www2.healthservice.hse.ie/organisation/ncca/
Q – (A community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care). https://q.health.org.uk/get-involved/events/
Delivering Change in Health Services - Complete Guide www.hseland.ie

Communications, Teaming and Systems

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Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

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National Ambulance Service

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Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

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Communication, Teaming and Systems for Patient/Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I know where to find services, supports and information relevant to my needs.	
I communicate with my health care providers to express my needs and preferences, ask questions, raise concerns and give feedback.	
I understand the human and system factors that can impact on performance and well-being.	

What this looks like

I communicate effectively with my healthcare provider team and appreciate the principles of human factors and systems to improve patient care and outcomes.

How to learn more about Communication, Teaming and Systems

Read a Policy, Procedure or Guideline
An Introduction to Human Factors for Healthcare Workers https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf
Health Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/
The Health Literacy Place https://www.healthliteracyplace.org.uk/
HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

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Working as a Team for Improvement www.hseland.ie
National Healthcare Communication Programme https://www.hse.ie/eng/about/our-health-service/healthcare-communication/
Irish Human Factors and Ergonomics Society https://ihfes.org/
Clinical Human Factors Group – The Health Foundation https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group
A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19
How to turn a group of strangers into a team: https://www.ted.com/talks/amy_edmondson_how_to_turn_a_group_of_strangers_into_a_team/transcript?subtitle=en

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

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PLAY VIDEO

Select the page icon to view a transcript of the video

Sustainability for Patient/Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the importance of using health care resources wisely and in environmentally aware way.	

What this looks like

I appreciate the sustainable use of healthcare resources to maintain quality and safe healthcare for the long term.

How to learn more about Sustainability

Read a Policy, Procedure or Guideline
HSE Climate Action Strategy https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Resources to support you
RCSI Sustainable Healthcare Online https://www.rcsi.com/online/courses/sustainable-healthcare/course-details
World Health Organisation Online Course https://www.who.int/teams/environment-climate-change-and-health/training
Global Health e-learning https://rise.articulate.com/share/eC-tXqaq7BzR7Kl8N1OGu86Th-gNvArl#/
Carbon Basics – Create an SEAI account to avail of training https://energylink.seai.ie/login
National Health Sustainability Office https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/
17 United Nations Sustainable Development Goals https://www.un.org/sustainabledevelopment/sustainable-development-goals/
Centre for sustainable healthcare https://sustainablehealthcare.org.uk/
Green Health Care https://greenhealthcare.ie/

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for Patient/Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the importance of providing feedback on my experience of care. This includes complaints, comments and compliments.	
I communicate about the quality and safety of care with my healthcare provider, organisation or other agency with the support of patient advocates as needed.	

What this looks like

I support and contribute to promoting a quality and patient safety culture.

How to learn more about Quality and Patient Safety Culture

Read a Policy, Procedure or Guideline
HSE Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955
National Standards for Safer, Better Healthcare – HIQA https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare
HSE 'Just Culture' Information https://www2.healthservice.hse.ie/organisation/qps-incident-management/just-culture/
Developing Organisational Culture – Guide for the Health Service https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

Resources to support you
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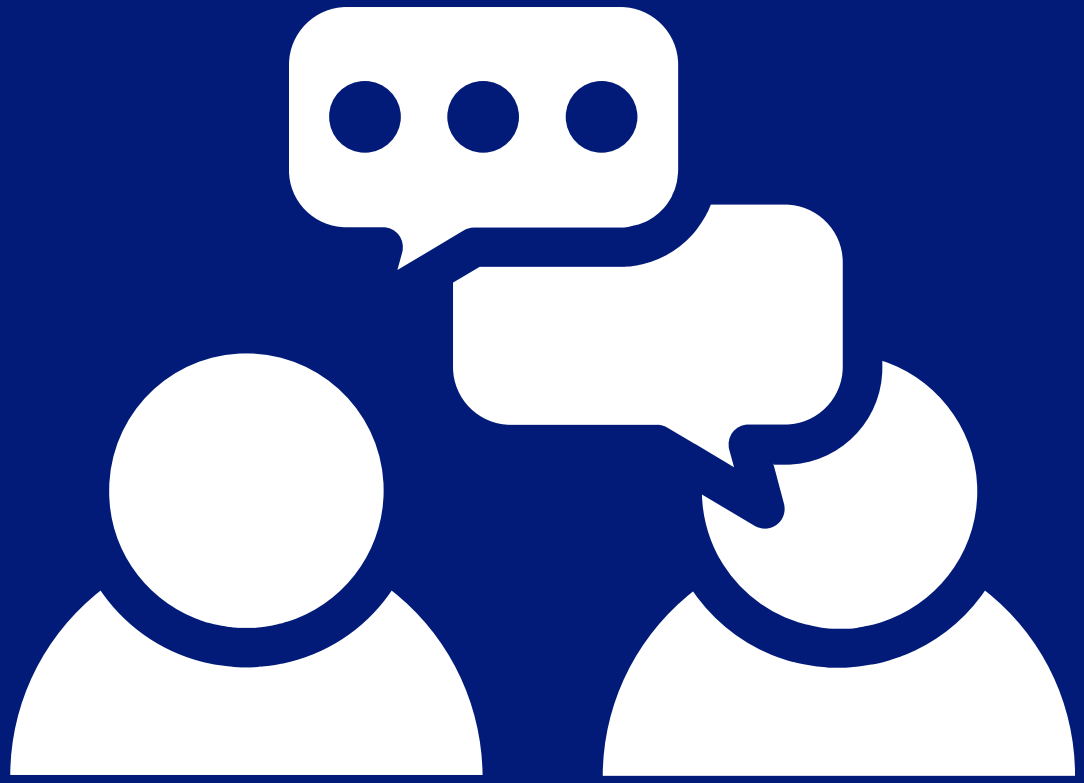
Foundation in Quality Improvement www.hseland.ie
Fundamentals of Clinical Audit www.hseland.ie
Situational Awareness for Everyone (SAFE) Collaborative – See QPS Prospectus https://www2.healthservice.hse.ie/organisation/qps-education/education-and-learning-programmes/
Patient Safety Together: learning, sharing and improving website https://www2.healthservice.hse.ie/organisation/nqpsd/pst/
Safety Culture (NHS) https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture/
A Culture of Safety https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/a-culture-of-safety-by-j-fitzsimons.pdf

On the path to mastery in Quality and Patient Safety

Those who are passionate about deepening their understanding of quality and patient safety. They influence, coach, educate and support others to improve the quality and patient safety of their organisation.



PREV

NEXT

RETURN TO CATEGORIES

STEP 2

Select the topic you would like to explore

These are the key topic areas for developing quality and patient safety competence. All topics are of equal importance. The number of competencies and range of resources may vary for each.

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Safety, Risk and Incident Management

Una Healy,
Lead Clinical Safety & Risk Manager in St James's Hospital

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Mastery in Safety, Risk and Incident Management

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I advise on how to apply safety regulation and standards, the Enterprise Risk Management Policy, the Incident Management Framework, Open Disclosure Policy and Just Culture Guide.	
I identify and assess the risks that impact organisational objectives and national policy.	
I develop and implement strategic risk management plans that align with organisational objectives.	
I communicate risk information clearly to internal and external stakeholders.	
I use advanced tools to monitor, analyse and report on all relevant data which enables data-driven decision-making.	
I coach and mentor colleagues to lead safety, risk and incident management activities or processes.	
I advise committees and groups on issues relating to safety, risk and incident management.	
I facilitate learning and teach others on safety, risk and incident management in healthcare.	
I share learning from safety, risk and incident management at local, regional, national and international levels.	
I support others and the broader healthcare service when things go wrong.	
I coach and support others involved in coroner hearings and legal proceedings.	

What this looks like

I advise, influence, research, teach, coach and support others in the management of safety, risk and incidents.

How to learn more about Safety, Risk and Incident Management

Learn while you work (in-practice development opportunities)

1. Shadow a colleague leading a risk assessment review.
2. Take part in complex safety reviews.
3. Take part in the development of quality improvement plans for the implementation of recommendations.
4. Shadow a colleague attending a coroners inquest.
5. Shadow a colleague leading an open disclosure meeting.
6. Co-deliver training on human factors, risk management, incident management and open disclosure.

Read a policy, procedure or guideline

ISO Standards https://www.nsai.ie/standards/sectors/risk-management/

Committee of Sponsoring Organizations of the Treadway Commission: https://www.coso.org/

National Risk Assessment 2023 https://www.gov.ie/en/press-release/311d3-government-publishes-national-risk-assessment-2023-outlining-top-strategic-risks-facing-ireland/

DPER Risk Management Guidance https://www.gov.ie/pdf/?file=https://assets.gov.ie/138811/bafddf9c-f448-4e3a-bfcd-2f6281256df1.pdf#page=null

HMT Orange Book https://assets.publishing.service.gov.uk/media/6453acadc33b460012f5e6b8/HMT_Orange_Book_May_2023.pdf

WHO Risk Management Strategy - WHO Risk Management Strategy https://www.who.int/publications/m/item/risk-management-strategy

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking advanced training in the area of safety, risk and incident management.

Many healthcare leadership programmes will cover these topics and some will be more specific such as;
-Human Factors in Patient Safety in Healthcare.
-Quality and Safety in Healthcare Management
-Healthcare Risk Management & Quality
-Managing Risk and System Change

Courses aimed at preparing healthcare professionals who may be required to attend or engage with the Coroner's court are available often through medical indemnifiers or other legal agencies.

Further Learning

HSE Enterprise Risk Management Website https://www.hse.ie/eng/about/who/riskmanagement/

HSE QPS Incident Management Website https://www2.healthservice.hse.ie/organisation/qps-incident-management/

State Claim Agency https://stateclaims.ie/
Institute for Healthcare Improvement https://www.ihi.org/
International Society for Quality in Healthcare https://isqua.org/
The Health Foundation https://www.health.org.uk/
Agency for Health Research and Quality https://www.ahrq.gov/
THIS.Institute https://www.thisinstitute.cam.ac.uk/

Hopkin, P. (2018) Fundamentals of Risk Management: Understanding, Evaluating and Implementing Effective Risk Management. (5th edition)

Partnering with People

Tiberius Pereira
Co-Founder, Patients for Patient Safety Ireland

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Mastery in Partnering with People

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I advocate for a culture of partnering with people and promote person-centred care.	
I promote partnership with people as a strategic priority.	
I use engagement tools and methods to work together with staff and patients in improving the design and delivery of care.	
I ensure that a diverse range of patients work with my organisation to support quality and safety.	
I work to ensure involvement from underserved and/or underrepresented communities in service design, development, delivery and evaluation.	
I ensure my organisation has performance measures to monitor patient engagement, share data and take action as appropriate.	
I coach and train others undertaking co-design and co-production in quality and patient safety.	
I advocate for resources to support partnering with people who use our health services.	

What this looks like

I advocate for patient-centered care with effective collaboration among diverse stakeholders and co-design coaching to enhance quality and patient safety.

How to learn more about Partnering with People

Learn while you work (in-practice development opportunities)

1. Deliver training to support staff develop their skills in partnership, co-design and collaboration.
2. Involve patients and families in the co-design of healthcare services and facilities to create more user-friendly, patient-centred environments.
3. Mentor colleagues who want to develop their knowledge and skills in co-design and co-production.

Read a Policy, Procedure or Guideline

Better Together – Health Services Patient Engagement Roadmap https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf

HSE QI Knowledge and Skills Guide – Person and Family Engagement https://www.hse.ie/eng/about/who/nqpsd/qps-education/full-document.pdf

Resources for partnering with people https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/resourcesqid/

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking post graduate training in the area employee engagement or public and patient involvement (PPI). Many healthcare leadership programmes will cover these topics. There are also other courses on co-production and co-design available online and in person.

Further Learning

HSE Partnering with Patients Website https://www.hse.ie/eng/about/who/national-services/partnering-with-patients/

AHRQ Patient and Family Engagement: https://www.ahrq.gov/topics/patient-and-family-engagement.html

HSE Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

QPS Talk-Time Webinars on Patient Partnership https://www2.healthservice.hse.ie/organisation/qps-connect/qps-talktime/

Walk and Talk Improvement Podcasts: The importance of patient partners. https://www2.healthservice.hse.ie/organisation/qps-connect/walk-and-talk-improvement-podcast-series/

Quality Improvement and Clinical Audit

Dr John Fitzsimons
Consultant Paediatrician and Clinical Director for Quality Improvement

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Mastery in Quality Improvement and Clinical Audit

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I understand the principles of audit, research and service evaluation and differences between.	
I can describe what is meant by maintaining quality control and quality assurance.	
I understand the importance of measurement in QI to analyse, improve and maintain quality.	
I can define the common barriers to and enablers of quality improvement.	
I can create and use QI measurement tools such as statistical process control (SPC) and run charts.	
I understand the importance of testing in QI and the concept of small tests of change.	
I understand the benefit of standardisation to deliver a quality safe service.	
I understand the importance of continually monitoring the quality of a service and identifying and collaboratively solving issues in a timely manner, escalating as necessary.	
I understand the importance of openness and transparency in maintaining quality.	
I am open to agreed innovation.	
I support and use multi-source feedback to support learning and improvement.	

What this looks like

I advocate for learning and continuous improvement to deliver safe, high-quality services.

Mastery in Quality Improvement and Clinical Audit

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I identify opportunities to learn from daily practice to improve.	
I create and participate in opportunities to develop, share, analyse and reflect on learning.	
I enable staff to speak up, act on and celebrate their contribution to continuous learning and improvement.	
I champion the use of IT to support data collection and measurement.	
I aim to build, develop and engage with learning communities locally, nationally and internationally.	
I am confident in delivering training in Quality Improvement and/or Clinical Audit.	
I am confident as a Quality Improvement/Clinical Audit Facilitator.	
I can effectively lead and take part in quality improvement research.	
I apply a project management approach to quality improvement projects.	
I apply economic models, frameworks and evaluation techniques to support quality and safety decision making.	
I apply the concepts of value based healthcare to quality and safety decision making.	

What this looks like

I advocate for learning and continuous improvement to deliver safe, high-quality services.

How to learn more about Quality Improvement and Clinical Audit

Learn while you work (in-practice development opportunities)

1. Coach a team on their QI project.
2. Present your own clinical audit and QI findings to colleagues for peer review and constructive feedback on how to improve future efforts.
3. Attend and present your work at conferences or forums: Participating in conferences, webinars or forums focused on quality improvement or clinical audit can help you learn from experts, network, and gain inspiration for new projects (e.g., SPARK, EQUIPS, NPSO).
4. Deliver training to staff on the principles, methods and tools of clinical audit and quality improvement, including how to identify areas for improvement.

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking advanced training in the area of quality improvement and clinical audit in healthcare

Many higher education institutes offer advanced training for example;
-Quality and Safety in Healthcare Management
-Healthcare Risk Management & Quality
-Managing Risk and System Change

The RCPI Post Graduate Certificate Quality Improvement Leadership in Healthcare is funded by the HSE. https://courses.rcpi.ie/product?catalog=Postgraduate-Certificate-in-Quality-Improvement-Leadership-in-Healthcare

How to learn more about Quality Improvement and Clinical Audit

Read a Policy, Procedure or Guideline
HSE Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955
World Health Organisation https://www.who.int/health-topics/quality-of-care
ISQUA https://isqua.org/resources-blog/resources.html
Institute for Healthcare Improvement https://www.ihi.org/resources/tools
Oxford Professional Practice: Handbook of Quality Improvement in Healthcare https://global.oup.com/academic/product/oxford-professional-practice-handbook-of-patient-safety-9780192846877?cc=us&lang=en&
NHS Senior leadership Improvement and Innovation https://senioronboarding.leadershipacademy.nhs.uk/new-setting-strategy-and-long-term-transformation/new-improvement-and-innovation/
International Journal for Quality in Health Care https://isqua.org/resources-blog.html
BMJ Quality & Safety https://www.health.org.uk/funding-and-partnerships/our-partnerships/bmj-quality-safety
NICE Best Practice in Clinical Audit https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf
HSE Healthcare audit criteria and guidance https://www.lenus.ie/bitstream/handle/10147/305196/guid.pdf?sequence=1&isAllowed=y

Further Learning
UK Berwick Review into Patient Safety (2013) https://www.gov.uk/government/publications/berwick-review-into-patient-safety
Health Foundation Developing learning health systems in the UK: Priorities for action https://www.health.org.uk/publications/reports/developing-learning-health-systems-in-the-uk-priorities-for-action
Q Community Insight: Quality Management Systems in health and care https://q.health.org.uk/insight/quality-management-systems/
Q Community: A deeper look into Quality Management Systems https://q.health.org.uk/resource/a-deeper-look-into-quality-management-systems/Patient Safety
THIS Institute Cambridge https://www.thisinstitute.cam.ac.uk/
Health Foundation https://www.health.org.uk/
The Kings fund http://www.kingsfund.org.uk/
NHS Scotland Quality Improvement Hub http://www.qihub.scot.nhs.uk/education-and-learning/qi-e-learning.aspx https://healthtechnology.wales/wp-content/uploads/2023/10/Health-Economics-101.pdf https://healtheconomicsunit.nhs.uk/ https://eithealth.eu/news-article/creating-impact-what-is-value-based-healthcare/
Link to open access online course: https://eithealth.eu/programmes/hta-high-value-care/

Communications, Teaming and Systems

Select the Play button to learn about this topic and to find out why it is important in healthcare.

Winifred Ryan
National Healthcare Communication Programme

PLAY VIDEO

Select the page icon to view a transcript of the video

Ciarán McCullagh
National Ambulance Service

PLAY VIDEO

Select the page icon to view a transcript of the video

Dr Marie Ward
PhD Human Factors Ergonomics Health Systems Research and Learning Facilitator

PLAY VIDEO

Select the page icon to view a transcript of the video

Mastery in Communication, Teaming and Systems

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I have an in-depth understanding of human factors and apply Human Factors' principles, tools and methodologies to enhance system performance.	
I perform usability assessments to support the safe application and evaluation of technology.	
I can identify the factors that contribute to the success of high reliability organisations.	
I support and train others to be effective communicators in the healthcare setting.	
I apply conflict resolution and negotiation skills to bring people together to reach a mutually satisfactory agreement.	
I apply facilitation skills in bringing teams together to promote quality and patient safety.	
I support and train others to develop their skills in human factors.	
I promote the use of simulation resources for improvement work and education to clinical leaders.	
I advise committees and groups on issues related to communication, teaming and human factors.	

What this looks like

I advocate for the application of human factors principles, tools, and methodologies to enhance system performance, improve quality and patient safety.

How to learn more about Communication, Teaming and Systems

Learn while you work (in-practice development opportunities)

1. Lead debriefing sessions in the analysis of incidents and near misses to uncover how human factors contributed to these events (e.g., after action reviews, systems analysis).
2. Engage in training sessions that bring together different healthcare professionals to practice working collaboratively and understand each other's roles.
3. Lead simulation training for staff that mimics real-life clinical situations that require effective teamwork, fostering skills like communication and coordination and promote role clarity.

Read a Policy, Procedure or Guideline

An Introduction to Human Factors for Healthcare Workers https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/a-guide-to-human-factors-in-healthcare-2021.pdf

Health Services Change Guide https://www.hse.ie/eng/staff/resources/changeguide/

The Health Literacy Place https://www.healthliteracyplace.org.uk/

HSE Communicating Clearly Guidelines https://www.hse.ie/eng/about/who/communications/communicatingclearly/

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking advanced training in the areas of communication, teaming and human factors.

Many healthcare leadership programmes will cover the topics of communication and teaming and some Higher Education Institutes will offer advanced training specific to human factors such as;
-Human factors and patient safety.
-Human factors and ergonomics.
-Patient safety and clinical human factors.
-Human Factors in healthcare.
-Healthcare Simulation and Patient Safety.

Further Learning

Irish Human Factors and Ergonomics Society https://ihfes.org/

Clinical Human Factors Group – The Health Foundation https://www.health.org.uk/funding-and-partnerships/programmes/clinical-human-factors-group

HSE National Simulation Office https://www.hse.ie/eng/about/who/national-simulation-office/

A brief Introduction to Teaming https://www.kingsfund.org.uk/insight-and-analysis/articles/introduction-teaming-covid19

HSE Leadership, Learning and Talent Management programmes https://healthservice.hse.ie/staff/training-and-development/training-programmes-for-all-staff/

How to turn a group of strangers into a team https://www.ted.com/talks/amy_edmondson_how_to_turn_a_group_of_strangers_into_a_team/transcript?subtitle=en

Sustainability

Dr Philip Crowley
HSE National Director of Wellbeing, Equality, Climate and Global Health

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Mastery in Sustainability

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I implement sustainability best practices in quality and patient safety.	
I advise on the design of environments that reduce waste and makes sustainable choices convenient, and easy.	
I promote initiatives to reduce, avoid or replace the carbon footprint of healthcare.	
I help to integrate sustainability training in my organisation to promote quality and patient safety.	
I support my organisation in cross/inter-sectoral initiatives to promote sustainability for quality and patient safety.	
I consider and support suggestions from others about making the way we work more sustainable.	
I promote and support sustainability programmes in my workplace	
I work to ensure sustainability is factored into organisational decision making.	

What this looks like

I advocate for sustainability in my organisation and support others to learn about the importance using health care resources appropriately.

How to learn more about Sustainability

Learn while you work (in-practice development opportunities)

1. Deliver training on environmental sustainability in healthcare, focusing on waste reduction, energy efficiency, and eco-friendly practices.
2. Establish sustainability committees or green teams that promote environmental initiatives and peer learning.
3. Apply the principles of sustainability in clinical settings, such as reducing overuse of supplies and adopting reusable medical equipment where appropriate.
4. Attend relevant conferences such as the HSE and Climate Action Alliance.
5. Use the IHI sustainability planning worksheet to implement QI sustainability initiatives.
6. Use QI or LEAN methodologies to reduce waste.
7. Consider virtual care and communication where appropriate.

Read a Policy, Procedure or Guideline

HSE Climate Action Strategy
https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf

Sustainability in quality improvement (SusQI): a case-study in undergraduate medical education https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-02817-2

Sampath B, Feske-Kirby K, Gerwig K. Decarbonization starts at the top. Healthcare Executive. 2023;39(5):44-47
Sampath B, Jensen M, Lenoci-Edwards J, Little K, Singh H, Sherman JD. Reducing Healthcare Carbon Emissions: A Primer on Measures and Actions for Healthcare. Organizations to Mitigate Climate Change. (Prepared by Institute for Healthcare Improvement under Contract No. 75Q80122P00007.)
AHRQ Publication No. 22-M011. Rockville, MD: Agency for Healthcare Research and Quality; September 2022.

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking advanced training in the area of sustainability and climate action.

There is a growing number of advanced programmes available in higher education institutes such as;
-Sustainable Healthcare
-Climate Action and Sustainability
-Sustainability in Enterprise
-Environmental Sustainability, Climate, Justice and Sustainability.

Further Learning

IHI Sustainability Planning Worksheet https://www.ihi.org/resources/tools/sustainability-planning-worksheet

UK Health Alliance on Climate Change https://ukhealthalliance.org/

WHO Environment, Climate Change and Health https://www.who.int/teams/environment-climate-change-and-health/training

Green Health Care https://greenhealthcare.ie/

Global Health Curriculum for Specialist Medical Training in Ireland https://www.theforum.ie/wp-content/uploads/2023/11/Global-Health-Curriculum-Final-for-Print.pdf

Quality and Patient Safety Culture

Karl Brogan
Quality Safety and Service Improvement HSE Dublin and Midlands

Select the Play button to learn about this topic and to find out why it is important in healthcare.

PLAY VIDEO

Select the page icon to view a transcript of the video

Quality and Patient Safety Culture for Patients and Patient Partners

What I need to know and be able to do Read each statement and select the areas that you need to learn more about	**I need to learn more about this** Select all that apply
I measure safety culture and lead on initiatives to enhance safety culture in my organisation.	
I champion a quality and safety environment within my workplace and support others in promoting positive culture of quality and patient safety.	
I support everyone to 'speak up' about quality and safety issues and encourage others to do the same.	
I share learning locally on quality and patient safety based on national and international evidence.	
I share learning on quality and patient safety at regional, national and international levels.	

What this looks like

I advocate for enhancing safety culture, promoting quality and safety environments, encouraging open communication, and sharing learning globally.

How to learn more about Quality and Patient Safety Culture

Learn while you work (in-practice development opportunities)

1. Lead your organisation's Quality & Patient Safety Committee.
2. Review data such as patient feedback, KPIs, audit results, investigation/evaluation reports to identify quality and patient safety issues and areas for improvement.
3. Lead a safety huddle or safety pause.
4. Lead a Schwartz round.
5. Introduce safety rounds with leadership where concerns are addressed and staff are encouraged to openly discuss safety issues and improvement opportunities.
6. Encourage the reporting of near-miss or 'good catch' incidents and take part in discussions about how they occurred, fostering a proactive approach to preventing errors.

Complete a learning programme

In addition to the learning resources identified in the QPS Roles & QPS Champion section, you may want to consider undertaking advanced training in the areas of quality and patient safety.

Many Higher Education Institutes will offer advanced training specific to quality and patient safety such as;
-Patient Safety and Quality Improvement
-Patient Safety
-Advancing Practice for Patient Safety
-Quality and Safety in Healthcare

How to learn more about Quality and Patient Safety Culture

Read a Policy, Procedure or Guideline
Patient Safety Strategy – https://www.lenus.ie/handle/10147/626955
National Standards for Safer, Better Healthcare – HIQA https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare
HSE 'Just Culture' Information https://www2.healthservice.hse.ie/organisation/qps-incident-management/just-culture/
Improving patient safety culture – a practical guide https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/
Developing Organisational Culture – Guide for the Health Service https://assets.hse.ie/media/documents/Developing_Organisational_Culture_-_Guide_for_the_Health_Service.pdf

Further Learning
Patient Safety Together: learning, sharing and improving website https://www2.healthservice.hse.ie/organisation/nqpsd/pst/
Health Information and Quality Authority Website https://www.hiqa.ie/
AHRQ Surveys on Patient Safety Culture https://www.ahrq.gov/topics/surveys-patient-safety-culture.html
The Health Foundation: The Measuring and Monitoring of Safety https://www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf
UK Berwick Report (2013) https://www.gov.uk/government/publications/berwick-review-into-patient-safety
Safety Culture (NHS) https://www.england.nhs.uk/patient-safety/patient-safety-culture/safety-culture
Institute for Healthcare Improvement https://www.ihi.org/
THIS Institute Cambridge https://www.thisinstitute.cam.ac.uk/
The Health Foundation https://www.health.org.uk/
WHO https://www.who.int/
ISQUA https://isqua.org/
Patient Safety Legislation and Advocacy https://www.gov.ie/en/publication/97de69-patient-safety-and-advocacy-policy/
Evidence Based Quality Improvement and Patient Safety Research www.equips.ie

BACK TO WHERE I WAS

Safety Risk and Incident Management

Healthcare is complex. It relies on many factors working together so that patients and service users receive quality safe care. However, despite everyone's best efforts, things can go wrong. That's why we need safety, risk and incident management processes. It's also why we need open disclosure after patient safety incidents.

What is Safety, Risk and Incident Management all about?

Safety management is about preventing accidents, injuries and other adverse events in healthcare. Each of us manages risks every day, in our homes, as we travel and while we work. Risk and uncertainty are part of everyday healthcare.

Managing risk involves anticipating potential problems. It means putting systems and procedures in place to avoid them happening. It also involves minimising their effects if they do happen. This is crucial to ensure patient safety and quality care.

Enterprise risk management is another term we use. It relates to a framework for making decisions based on risk. This helps organisations to address their risks as a whole, rather than one by one.

Incidents are events that could have or did lead to unintended or unnecessary harm. Incidents can happen in different ways. They can be adverse events where harm occurred, for example a medication error. They can also be near misses where harm did not occur. An example is using outdated patient equipment. They also include safety concerns raised through complaints, audits or staff feedback.

Open disclosure involves being open and honest with those affected by an incident. This includes when someone experiences harm during their care.

The **HSE National Incident Management Framework** helps us to manage incidents in a way that is sensitive to the needs of those affected. It also helps healthcare services to learn and improve. Healthcare providers must identify, report and review all incidents. This helps everyone to learn from and make improvements after an incident occurs.

BACK TO WHERE I WAS

Partnering with People

Partnering with people is essential for designing and delivering safe, quality, person-centred care.

What is Partnering with People all about?

Partnering with people is about healthcare staff working with patients, service users, communities and the public. It's about listening to their perspectives. It's about helping them gain knowledge, skills and confidence for decision-making. This includes decisions about their own health and health care. It also includes decisions about healthcare service design, delivery and evaluation as well as healthcare policy. Working together is central to improving healthcare services.

Patients should feel comfortable to express their needs, preferences and beliefs and healthcare staff should listen to and consider their ideas, experience and expertise.

Partnering with people means working together to improve services at all levels across our healthcare system.

BACK TO WHERE I WAS

Quality Improvement and Clinical Audit

Quality Improvement and Clinical Audit help us to provide safer, better care. They promote continuous improvement and learning across healthcare organisations.

What is Quality Improvement and Clinical Audit all about?

Quality Improvement and Clinical Audit are two important tools in healthcare. We use them to help patients receive the best possible care.

Quality improvement is about finding ways to make healthcare better. For example, improving patient safety, effectiveness and equity. It also includes timeliness, efficiency and person-centred care. Sustainability has recently become an important part of quality improvement. We can achieve quality healthcare using a reliable, consistent, and coordinated systems approach. This helps us to promote and enable quality and learning across healthcare organisations. This means that quality and patient safety is everyone's business.

Clinical audit is a quality improvement process. It aims to ensure the quality of the healthcare we provide. In a clinical audit we review the standard of care against defined standards and guidelines. We also identify areas for improvement. This helps to ensure patients receive quality care. It also helps staff to improve their knowledge and skills.

There are three main elements of a quality management system. These are; planning for quality, quality improvement and actively maintaining quality.

Planning means setting goals and designing care delivery processes. It also means improving what we do, to meet the needs and preferences of service users.

Quality improvement means trying new and better ways of working. It also includes using data for evaluation.

Actively maintaining quality includes quality control and quality assurance and relies on the transparent and open sharing of data.

Quality control means measuring performance and taking action when standards are not met.

Quality assurance checks and ensures our quality control mechanisms. It also considers the broader healthcare system. For example, how well teams and organisations work to ensure quality planning, improvement and learning.

BACK TO WHERE I WAS

Communication

Communication is central to safe and effective healthcare. It helps people to work together to provide the best possible care for patients for the people who use our services.

What is Communication in healthcare all about?

Effective communication is the process of exchanging ideas, thoughts, opinions and information. It helps people to receive and understand our messages. It is important that our communication is clear, correct, complete and concise and that our language is appropriate and compassionate. We must also be ready to adapt our communication, depending on the needs of the situation and people involved.

There are many types of communication we can use. For example verbal and non-verbal, written, visual, and listening. We can communicate in person, over the phone or by post. We can also communicate virtually through websites, mobile apps and video calls. Effective communication within and between healthcare teams is vital. It helps us to coordinate care and involve the right team members in delivering care. It also helps us to run services more efficiently.

Communication is important in building trust between patients, families and healthcare providers. Telling people what's happening and what comes next can help reduce their anxiety. Good communication also helps people to make informed choices about their care, their health, and their wellbeing.

Research shows that effective communication between patients and healthcare providers reduces errors. It also improves treatment outcomes and improves patient and staff experience.

BACK TO WHERE I WAS

Teaming

Healthcare is always changing. We need skills to be able to adapt and work with others to ensure the best care for patients. This is where Teaming comes in.

What is Teaming in healthcare all about?

Team-based healthcare means working together to deliver healthcare services to patients, service users and communities. A team is two or more people with specific roles, who interact with each other towards a common and valued goal. A healthcare team will usually include several disciplines. For example nurses, doctors, administration and support staff and health and social care professionals including ambulance services. Each member offers specialised services in partnership with the patient/service user and their care givers.

Teaming is different from traditional approaches to teamwork. It recognises that people work in many different teams in healthcare. It also recognises that teams are rarely neatly-bound and defined.

Teaming adopts the mindset and practices of teamwork, but it also involves working with others without fixed team structures. The demands of healthcare are always evolving. Because of this, staff must be prepared to work in and with different teams..

BACK TO WHERE I WAS

Systems and Human Factors

It's important to recognise that many parts of a system can influence the outcomes of patient care. This knowledge can help us to design safer systems that work for everyone.

What is Systems and Human Factors in healthcare all about?

Human Factors is about understanding and improving how individuals interact with their work systems, including the processes they use and the environment they work in. We can use Human Factors to look at how tools, technology and tasks affect system performance. We can also use it to look at the organisation, the people in it and the physical environment around them. All these factors interact with each other. Making changes to one or more can improve performance and outcomes across the system.

Human Factors is about understanding and improving how individuals interact with their work systems, including the processes they use and the environment they work in. We can use Human Factors to look at how tools, technology and tasks affect system performance. We can also use it to look at the organisation, the people in it and the physical environment around them. All these factors interact with each other. Human factors considers non-technical skills that are important in providing quality, safe care. This includes cognitive skills, such as situational awareness and decision-making. It takes account of personal resources, like coping with fatigue and stress. It also includes social skills, like teamwork and communication.

In Human Factors we need to understand and develop these non-technical skills as they help us to deliver safer quality care. They will help us design better tools, equipment, systems, jobs and environments to make healthcare user-friendly, effective and safe and promote greater wellbeing for all and improve system performance.

BACK TO WHERE I WAS

Sustainability

The climate crisis is accelerating and the earth is getting warmer. Healthcare has a major impact on global greenhouse gas emissions. Sustainability is critical pillar of quality and embedding sustainability in healthcare means making choices. These choices should protect the long-term wellbeing of both people and the environment.

Sustainability in this context (environmental sustainability) is different from sustainability in quality improvement. When something is ‘sustained’ in quality improvement, the change has become the norm and embedded into the ways of working rather than something ‘added on’.

What is sustainability in healthcare all about?

The healthcare sector is a major contributor to global greenhouse gas emissions. It’s also vital in protecting our health against the impacts of climate change. When planning healthcare, we need to plan for safe, quality services over the long term.

A sustainable healthcare system provides safe, quality care without negatively impacting the environment. Sustainability in healthcare looks at the social, environmental and economic factors that affect how we live and work.

Prioritising sustainability now is important for the future health of our population. For greater sustainability in healthcare, we must reduce carbon emissions and minimise pollution. We also need to promote low-carbon and eco-friendly solutions. This will help to ensure the health and well-being of future generations.

Our knowledge of how to ensure a sustainable healthcare system continues to grow and additional competencies will be identified and resources will develop over time.

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Quality and Patient Safety Culture

By promoting a quality and patient safety culture, healthcare organisations can prioritise the delivery of high-quality care while ensuring that patient safety remains the central focus of everything they do.

So what is quality and patient safety culture all about?

A quality and patient safety culture involves individual and organisational values and actions working towards improving the quality of services while minimising potential harm to patients from their daily care delivery.

It's a culture where organisations create and nurture an environment that supports everyone to deliver and receive excellent safe care. This involves everyone, individual staff, teams, patients, service users, families and care givers.

There are six main elements of a quality and patient safety culture:

- **It's an inclusive culture** where people are valued and respected in an environment free from discrimination.
- **It's an informed culture** of collecting and monitoring data. It's one of sharing quality and safety information openly and transparently, where engagement is encouraged from everyone involved.
- **It's a flexible culture** where everyone in the organisation adapts to changing demands and acknowledge the complex and dynamic nature of healthcare.
- **It's a reporting culture** where people feel safe reporting risks and quality and safety concerns. It's a just culture with a balanced review of incidents and accountability that doesn't seek to blame but seeks to examine all factors relating to a safety incident.
- **It's a learning culture** where people apply the learning from both excellence and from incidents to drive improvement in healthcare delivery.

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Glossary of Terms

Term	Explanation
Adverse event	An incident which results in harm, which may or may not be the result of an error.
Assisted	Assisted decision making is about supporting people to make decisions. It is also about maximising a person's capacity to make decisions, in line with the Assisted Decision-Making (Capacity) Act 2015.
Decision-Making	The Act recognises that, as far as possible, all adults have the right to play an active role in decisions that affect them. These decisions can be about their personal welfare, including health and social care. They can also be about their property and affairs.
Capability	The extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance.
Care plan	A plan that a patient, their family and their health care professionals design. It describes what kind of services and care a person should receive.
Clinical Audit	Clinical audit is a quality improvement process that is led by clinical staff. It aims to improve patient care and outcomes. The clinical audit team reviews care against defined standards and guidelines. It also identifies areas for improvement. Improvements, when needed, should be made at an individual, team or organisation level. Care can then be re-evaluated to confirm improvements.

Term	Explanation
Clinical governance	Clinical governance is a system used in healthcare organisations. It holds organisations accountable for continually improving the quality of their services. It also safeguards high standards of patient care. It involves creating an environment where excellent clinical care can thrive.
Collaboration	Working together to achieve a shared or agreed goal.
Communication	Sending or receiving information by speaking, writing, or using some other way.
Competence	The array of abilities [knowledge, skills, and attitudes] across multiple domains or aspects of performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training. Competence is multi-dimensional and dynamic. It changes with time, experience, and setting (Englander et al., 2013)
Competency	An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. (Englander et al., 2013)

NEXT

Glossary of Terms

Term	Explanation
Competency framework	An organised and structured representation of a set of interrelated and purposeful competencies.
Competency list	The description of the specific competencies within a competency framework.
Complex adaptive system	A system where a perfect understanding of the individual parts (individual, team, organisation) does not automatically result in a perfect understanding of the whole system behaviour. It consists of many diverse and autonomous parts. These parts are interdependent and linked through many interconnections and relationships. Control of the system is distributed instead of centralised. The system is able to change in response to feedback or stimulus from its environment. It adapts to new challenges and opportunities, making sense of disruption and chaos. In this way it can survive and thrive in new situations.
Confidentiality	Confidentiality means ensuring we maintain the privacy of service user data. This involves treating personal details and feedback with the highest level of confidence, consistent with public interest and the right to privacy.

Term	Explanation
Consent	Consent means giving permission or agreement for a treatment or investigation. It also means giving permission to receive or use a service, or to take part in research or teaching. Consent involves a process of communication about the proposed intervention. The person who is consenting must receive sufficient information. This is to enable them to understand the nature, potential risks and benefits of the proposed intervention. Seeking consent should occur as an on-going process rather than a one-off event. (HSE National Consent Policy).
Co-design	Co-design is an approach to design something by working together. For example, designing a health leaflet with staff, patients and other healthcare stakeholders.
Co-production	Co-production is about involving people with lived experience in service planning, design and delivery and evaluation.
Culture of quality and safety	A culture of quality and patient safety refers to a set of individual and organisational actions that aim to enhance the quality of services while minimising potential harm to patients from daily care delivery.

Glossary of Terms

Term	Explanation
Data protection	Data protection means keeping people's personal information private and safe. It ensures that this information is used legally and fairly. It also protects the information from being misused. For the purpose of Data Protection, organisations or individuals who control the contents and use of personal data are known as Data Controllers and are required to protect information collected about you in line with legal requirements (HSE).
Delphi	The Delphi method is a process used to arrive at a group opinion or decision by surveying a panel of experts.
Diversity	Diversity means including or involving people from a range of different backgrounds. For example, race, ethnicity, gender, sexual orientation, socio-economic status, age, physical or mental abilities, religious beliefs or political stance.
Domains of competence	Broad distinguishable areas of competence that in the together constitute a general descriptive framework for a profession.
Effective communication	Effective communication is the process of exchanging ideas, thoughts, opinions, knowledge, and information so that the message is received and understood with clarity and purpose. Key principles underlying good communication is that it should be clear, correct, complete, concise, and compassionate to be effective. It must also be adapted, depending on the needs of the situation.

Term	Explanation
Enterprise risk management	Enterprise Risk Management is a system that help make decisions based on risks. It guides the protection and improvement of healthcare services, ensuring they contribute to better healthcare outcomes. It helps organisations to manage uncertainties and the associated risks and opportunities. It also helps them to address their risks as a whole, rather than one by one.
Error	A human error is an action or decision which was not intended.
Health literacy	Health literacy refers, broadly, to the ability of individuals to "gain access to, understand and use information in ways which promote and maintain good health" for themselves, their families and their communities World Health Organization (WHO).
Health services	Where the words "health service" are used, it refers to all of the services provided by the Health Service Executive or the health system globally. This may include for example, health care, social care, primary care, mental health or community services. It is often broader than health.
HIQA	The Health Information and Quality Authority. The Health Information and Quality Authority is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland.

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Glossary of Terms

Term	Explanation
Human factors	Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety (HSE).
Implementation	The process of putting a decision, plan or programme into effect.
Incident	An incident refers to an event or circumstance which could have or did lead to unintended and/or unnecessary harm. Incidents include adverse events which are incidents which resulted in harm, near misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention.
Incident management	Systems and processes that promote a culture of quality, safe and effective care. Incident management ensures we can identify, report and review all incidents that occur in health care. This supports continuous learning and improvement.
Incident management framework	The HSE National Incident Management Framework provides an overarching practical approach, based on best practice, to assist healthcare staff and organisations to manage all incidents in a way that is sensitive of the needs of those affected and supports healthcare services to learn and improve.

Term	Explanation
Key performance indicators (KPIs)	Key performance indicators (KPIs) are measurable indicators. They show progress towards reaching a specified target. They help decision-makers to assess progress towards an outcome or goal within an agreed timeframe.
Meaningful engagement	Meaningful engagement means truly listening to your stakeholders and partners. It means giving people a voice and engaging with them on their opinions.
Measurement for improvement	Measurement for improvement involves analysing and presenting qualitative and quantitative data. This is done in a way that helps to identify opportunities for improvement.
Lean / Lean Six Sigma	Lean and Lean Six Sigma are process improvement methodologies. They focus on the customer/patient, the employee, management support and teamwork. They use data to find ways to improve quality, make systems more efficient, and reduce waste.
Near miss	An event or circumstance which could have resulted in harm, but did not cause harm, either by chance or timely intervention. (HSE Incident Management Framework)

Glossary of Terms

Term	Explanation
Non-Technical skills	Non-technical skills are the cognitive, personal resource, and social skills and skills that complement a healthcare worker's technical ability. (HSE – An introduction to Human factors for healthcare workers)
Open disclosure	Open disclosure is defined as an open, consistent, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety incidents. It includes expressing regret for what has happened, keeping the patient informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the health services provider to try to prevent a recurrence of the incident.
Patient and public involvement in research	This means collaborating and partnering with patients, carers, service users or the public on research. They will input on planning, designing, managing, conducting, disseminating and translating of research.
Patient engagement	This is the process of actively involving patients in their own healthcare. It means patient's needs, preferences, beliefs, experiences and expertise are heard and acted upon and that all involved have influence on the decisions being made.
Patient need	This is a desire or request given by a patient about their health.

Term	Explanation
Patient partnership	This means patients become involved, as little or as much as they want, across all areas of the health, social and community care sector.
Patient safety	This is about preventing errors and adverse effects to patients in their health care.
Person centred	A person-centred health system identifies and responds to the needs of individuals. It is planned and delivered in a coordinated way and helps individuals take part in decision-making to improve their health and wellbeing.
Person-centred care	Defined from a service user perspective: Person-centred coordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a complete assessment of my life and my world combined with the information and support I need. It respects my choices, builds care around me and those involved in my care. Defined from a staff perspective: Person-centred coordinated services means I have access to a range of human resource supports when I need them – from the time I apply for a job, through induction to my new role and team, ongoing support, supervision and personal development planning, feedback on how well I am doing at work, support when I feel stressed and opportunities to develop to my full potential. I also want to feel my contribution matters and that I can make a difference. (HSE Change Guide)

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Glossary of Terms

Term	Explanation
Plan-Do-Study-Act (PDSA) Cycle	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). (IHI)
Quality assurance (QA)	Quality Assurance is a means of maintaining quality. It is the process of evaluating performance on a regular basis. This provides confidence that the service will meet relevant quality standards.
Quality control (QC)	Quality Control involves checking how well a service is performing in real time and taking action if it doesn't meet the expected standards.
Quality improvement (QI)	The Kings Fund (2019) defines QI as "the systematic use of methods and tools to try to continuously improve the quality of care and outcomes for patients". Quality Improvement is about focusing on key areas agreed by the service as priority interventions and taking a collaborative and inclusive approach underpinned by QI principles and methods e.g. Model for Improvement to support implementation.
Quality management system	A reliable and consistent approach to support, promote and enable quality and learning across a healthcare organisation.

Term	Explanation
Learning health system	A learning health system is one where science, data, incentives and culture work together to keep improving and innovating. Best practices are integrated into every day work and new knowledge is captured as an integral by-product of the delivery experience.
Professional body	A Professional Body is an organisation maintains an oversight of the knowledge, skills, conduct and practice of a particular profession or occupation.
Psychological safety	Psychological safety means feeling safe to take interpersonal risks, to speak up, to disagree openly, to surface concerns without fear of negative repercussions.
Risk	Risk is the 'effect of uncertainty on objectives'. In the context of the healthcare services and delivery, it is any condition, circumstance, event or threat which may impact the achievement of objectives and/or have a significant impact on the day-to-day operations (HSE)
Risk management Policy	The 2023 Risk Management Policy sets out the policy and procedures by which the HSE manages risk.
Risk management process	The systematic way of using management policies, procedures and practices to manage risk. This involves communicating, consulting, establishing the context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.

Glossary of Terms

Term	Explanation
Safety management	Safety management involves applying a set of principles, frameworks, processes and measures to prevent accidents, injuries and other adverse incidents that may occur during the delivery of healthcare.
SEIPS model	Systems Engineering Initiative for Patient Safety Model. The SEIPS model is a theoretical model based on human-centred systems engineering or 'human factors/ergonomics. It has three major components, the work system, processes and outcomes. The key characteristics or factors of each all affect one another.
Social determinants of health	The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life World Health Organization (WHO) 7
Scoping literature review	A scoping review is a way of gathering knowledge on a given topic. It uses a systematic and iterative approach to identify and amalgamate an existing or emerging body of literature on the given topic.

Term	Explanation
Situational awareness	Situation awareness is an understanding of what is going on in a particular situation, or with a particular patient/service user. Put simply, situation awareness is how accurately your perception of the current environment matches reality. (HSE Human Factors Guide)
Stakeholders	Stakeholders are individuals or groups of individuals who are (or might be) involved in or use the health system or have a direct interest in or investment in the health system.
Strategy	A plan of action designed to achieve a long-term or overall aim.
Sustainability	Sustainable development is a process of economic, environmental and social change aimed at promoting the wellbeing of the population now and in the future. Sustainability is concerned with making choices in healthcare that minimise the impact on the environment. This is different from sustainability in quality improvement. When something is 'sustained' in quality improvement, the change has become the norm and embedded into the ways of working rather than something 'added on'.

Glossary of Terms

Term	Explanation
System	A set of things working together as parts of a mechanism or an interconnecting network. A healthcare system refers to the organisation of people, institutions and resources that deliver health care services to meet the health needs of specific groups of people.
Teaming	Teaming is “dynamic activity, not a bounded, static entity. It is largely determined by the mindset and practices of teamwork, not by the design and structures of effective teams. Teaming is teamwork ‘on the fly’. It involves coordinating and collaborating without the benefit of stable team structures, because many operations, like hospitals, require a level of staffing flexibility that makes stable team composition rare”. (Amy Edmondson, HBS)
Value based healthcare	The fair, sustainable and transparent use of available resources to achieve better outcomes and experiences for everyone. These resources include people, funding, equipment, buildings and time.
Work-as-done	Work-as-done refers to how the work is actually being done by healthcare workers.
Work-as-imagined	Work-as-imagined refers to how people in healthcare believe work is being performed

Select to go back to the Introduction

PREV

Quality and Patient Safety Competency Development Plan

This development plan is for your own personal and professional development. You may wish to share it with your Line Manager during your annual performance achievement discussions in order to agree and plan your QPS education and learning needs for the year ahead.

Note: If you already have a professional development plan template that you are required to use for your professional competence registration, you should use that instead.

You can copy and paste items directly into this plan, or alternatively, download a Microsoft Word version using the hyperlink here. To save this online version, simply click the 'save' icon.

Name	Job Title	Date

I need to learn more about the following topics *(tick as appropriate)*

Safety, Risk and Incident Management		Quality Improvement and Clinical Audit		Communication, Teaming and Systems	
Sustainability		Partnering with People		Quality and Patient Safety Culture	

I will complete the following learning programmes	I will read the following Policy/ Procedure/Guidelines	I will learn while I work by...	I will further my learning by...

I will complete the following learning programmes	I will read the following Policy/ Procedure/Guidelines	I will learn while I work by...	I will further my learning by...

My QPS Competency Development Action Plan

In 0-3 months I plan to...

In 4-6 months I plan to...

My QPS Competency Development Action Plan

In 7-9 months I plan to...

In 10-12 months I plan to...

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[1] McCarthy, S. E., Hammond, L., O'Mahony, J., Lachman, P., & Sorensen, J. (2024)., Defining Competencies in Health Economic Evaluation for Quality and Safety Practitioners: an explorative study, under review.

[2] Rathnayake, D., Hammoud, S., Browne, M., Hanlon, V., Moore, G., Fitzsimons, J., & De Brun, A. (2024) Exploring quality and patient safety competencies and competency-based framework approaches to enhance patient safety capabilities in healthcare professionals: A scoping review, under review.

Share your knowledge to help others

If you know of learning opportunities or resources that are not listed, or if you have suggestions for improving this resource, please provide us with information using the following link https://surveys.hse.ie/s/QPSNavigator/ and we will endeavour to include them in the next edition.

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