An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

Health Service Executive Ireland

National Quality and Patient Safety Directorate Report on strategic objectives of the Global Patient Safety Action Plan 2023

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The Health Service Executive (HSE) provides public health services in Ireland. It employes over 100,000 employees.

The National Quality and Patient Safety Directorate (NQPSD) is a team of health care professionals working within the national Health Service Executive (HSE) Ireland to improve patient safety and quality of care. We work in collaboration with Health Service Executive operations, patient partners, healthcare workers and other internal and external partners. Our work is guided by the Patient Safety Strategy 2019-2024.

Our vision for patient safety is that all patients using health and social care services will consistently receive the safest care. We work collaboratively in small teams across the directorate to do this by:

- Building quality and patient safety capacity and capability in practice **(QPS Education)**
- Using data to inform improvements **(QPS Intelligence)**
- Working with people to identify, understand and share safety learning, advocate for open disclosure and develop the national incident management system **(QPS Incident Management, Open Disclosure and Just Culture)**
- Providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements **(QPS Improvement)**
- Working to provide a recognised and trusted source of information for quality and patient safety **(QPS Connect)**
- Supporting Clinical Audit service providers locally and nationally **(National Centre for Clinical Audit)**
- Promote learning and best practice by reviewing serious cases (**National Independent Review Panel (NIRP)**)

In this document, we share a high level overview of our work in 2023 under the strategic objectives of the Global Patient Safety Action Plan 2021 - 2030. You can find out about our work and our team on www.hse.ie/nqpsd.

We invite you to contact us if you would like to learn more about any aspect of our work.

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

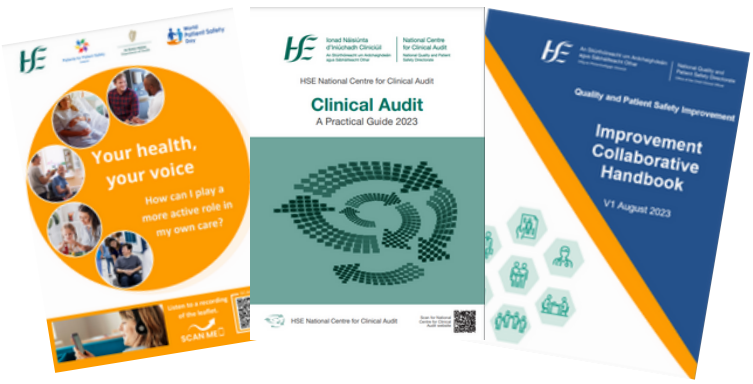
Strategic objective 1: Policies to eliminate avoidable harm in health care

Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere

- In 2023, the team continued to support the implementation of the six safety commitments of the Patient Safety Strategy 2019 - 2024 so that all patients will consistently receive the safest care possible. For example, there was a renewed focus on sepsis post pandemic and 2023 with the development of a 5year strategic plan and preparation for a public awareness campaign.

- The HSE National Centre for Clinical Audit is located within the patient safety function. This year we produced and published guidance: Clinical audit: A Practical Guide and a Clinical Audit Tooklit. This information seeks to provide comprehensive, user friendly information and guidance on conducting clinical audit for healthcare professionals.

- As part of a World Patient Safety Day collaboration between the Health Service Executive, Department of Health and Patient's for Patient Safety Ireland we developed an shared an extensive suite of resources for example: Your health, your voice leaflet, video clip and poster, Walk and Talk Improvement Podcast, QPSTalkTime Webinar, online and social media campaign elevating patient partner stories.



Strategic objective 2: High-reliability systems

Build high-reliability health systems and health organizations that protect patients daily from harm

The National Quality and Patient Safety Directorate has been working in collaboration with the services across the country to continute to build high-reliability health systems and organisation.

- On the 23rd May 2023, the Health Service Executive held it's first Just Culture Conference in Croke Park.
- The QPS Improvevment team launched the Improvement Collaborative Handbook to support services to lead, plan and implement collaboratives. Sustained benefits of collaboratives include the elimination of inefficiencies, improvement of reliability, enhancement of patient safety, and scaling of innovation and widespread implementation of best practice to protect patients from harm.
- The QPS Education team launched the HSE's first Human Factors learning programme (20 minute e-learning programme) available to for all staff and patient partners.
- The National Centre for Clinical Audit co-ordinated and facilitated new National Clinical Audits and Registries.

Strategic objective 3: Safety of clinical processes

Assure the safety of every clinical process

The National Quality and Patient Safety Directorate continued our efforts to work in collaboration with stakeholders to address the 13 common causes of harm. These are outlined on page 16 of the HSE Patient Safety Strategy 2019-2024 (PDF, 30 pages, 0.6MB) for example:

- National Medication Safety Programme
- Deteriorating Patient Improvement Programme
- National Improvement Programme in wound management
- QUICKPatientSafety Mobile App to Reduce Harm from Falls and Pressure Ulcers
- National Clinical Programme for Sepsis

The team has been working with clinical services to enable them to use improvement approaches to implement clinical care bundles such as the aSSKINg bundle to reduce the risk of pressure ulcers, the MOMEDS bundle to reduce the risk of harm from falls, and the Sepsis 6 bundle for the management of patients with sepsis, with the aim of increasing survival when all elements of the bundle are achieved.

Patient Safety Together Community

The team continued to build our national community for staff working in quality and patient safety in the Health Service Executive / Health Service Executive funded services to offer peer support and collaboration. In January 2023, we launched Patient Safety Together - a platform to share up-to-date patient safety information to help improve our health service for everyone, including healthcare workers, service users and clients. There is also an online community dedicated to QPS staff.

Patient Safety Supplements

Patient safety supplements share relevant quality and patient safety information for learning purposes and to raise awareness. 2023 supplements included:

- Early recognition and treatment of sepsis 20/12/2023
- Recognising surgical site infection at home 28/09/2023
- Recognising and Supporting Adult Safeguarding 30/05/2023
- The Risk of Smoking in our Acute Hospitals 22/02/2023

Health Service Executive National Patient Safety Alerts

Health Service Executive National Patient Safety Alerts are high-priority communications issued in relation to critical patient safety issues. Read more about Health Service Executive National Patient Safety Alerts. Alerts in 2023 include:

- Sepsis in Children and Young People 20/12/2023
- Risk of patient harm from medical device: Insufflation Unit 24/11/2023
- Potential risk of underdosing with calcium gluconate in severe hyperkalaemia 15/11/2023
- Medical Device Regulation and CE Marking (Conformité Européenne Marking) 16/10/2023
- HSE Paediatric Early Warning System (PEWS) Guidance 21/06/2023

Strategic objective 4: Patient and family engagement

Engage and empower patients and families to help and support the journey to safer health care

The National Quality and Patient Safety Directorate coordinates the inclusion of the patient voice at meetings of the Safety and Quality Committee of the Health Service Executive Board, by inviting patients and families to share stories of their care with the Board. Actively involving patients in this senior governance structure empowers them to support the journey to safer healthcare, and enhances patient-centered planning, design and decision-making in the health service.

In January 2023, Patient Partners working with the National Quality and Patient Safety Directorate were given access to HSELanD for the first time. This is the online staff training platform. This came from a request from individual partners and also because it is in keeping with the Directorate's ethos of building ways of learning together.

To evaluate their experience, a smart survey was issued to 17 patient partners. All those who responded recommended the platform would be made available to others.

In 2023, the National Quality and Patient Safety Directorate also became the Health Service Executive point of contact for Patients for Patient Safety Ireland to align with the Patient Safety Strategy.

This collaboration included:

- multiple articles in our newsletter Patient Safety Matters #AllThingsQuality including one member on our editorial review board.
- two Walk and Talk Improvement Podcasts with patient partners
- Quality and Patient Safety (QPS) QPSTalkTime webinars involving patient partners and a QPSTalkTime Patient Partner playlist.
- our national campaign for World Patient Safety Day - Your Health, Your Voice co-chaired by the chair of Patients for Patient Safety Ireland.
- Videos with members for multiple events such as open disclosure, National Patient Safety Office conference, World Patient Safety Day and so many more.
- Presentation to the Health Service Executive Board's Quality and Safety Committee.
- Members were also instrumental in the inaugural Patient and Public Partnership Conference.

Strategic objective 5: Health worker education, skills and safety

Inspire, educate, skill and protect health workers to contribute to the design and delivery of safe care systems

The National Quality and Patient Safety Directorate published their Prospectus of Education and Learning for the first time in 2023. This included a broad range of educational programme both online and face to face for staff and patient partners to access.

The team delivers programmes and resources aimed at building health workers' skills, knowledge and confidence in using improvement methods to address patient safety priorities. This enables our health service to deliver better care and outcomes for staff and patients.

In addition to programmes offered to all staff, in 2023, tailored programmes were co-designed and delivered to multidisciplinary teams involved in:

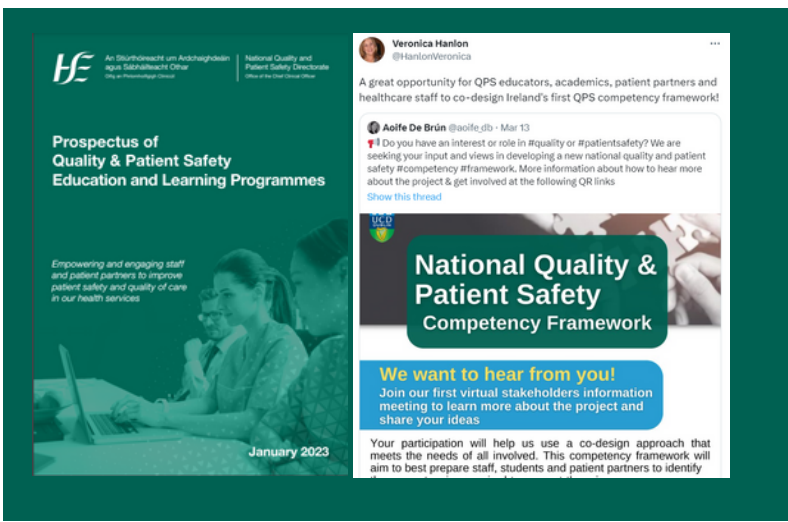
- Early Intervention in Psychosis
- Acute Hospital End of Life Care
- Critical Care Outreach
- Sepsis and the Deteriorating Patient
- Tissue viability / pressure ulcers
- Stroke
- ST segment elevation myocardial infarction (STEMI)
- Intensive care unit / Emergency department triage
- Falls prevention in residential services for adults with disabilities, and older persons
- Hospice care services

Another example is clinical audit training. The Health Service Executive National Centre for Clinical Audit rolled out a suite of education and training in clinical audit, both virtual and in-person. In 2023, there were 622 participants on our certified courses.

The first co-design workshop for the development of a National Quality and Patient Safety Competency Framework was held in Dublin on 12th July 2023 and was attended by people from across the health service, patients and academic partners. Work is ongoing to refine the outputs of this work though sub groups.

The Health Service Executive National Centre for Clinical Audit has been involved in several publications and promotional opportunities to spread the message about the importance of clinical audit as a tool for quality improvement. Examples include hosting clinical audit workshops, rolling out in person education for nurses in the North West, various publications across Health Service Executive publications and the use of social media platforms (X and LinkedIn), to inform healthcare professionals about upcoming educational sessions and share new clinical audit tools and resources that can be used to enhance patient safety.

The Health Service Executive National Centre for Clinical Audit promoted clinical audit as an essential quality and patient safety tool in Irish healthcare during Clinical Audit Awareness Week from the 19th - 23rd June.



Strategic objective 6: Information, research and risk management

Ensure a constant flow of information and knowledge to drive the mitigation of risk, a reduction in levels of avoidable harm, and improvements in the safety of care

In May 2023, the President of Ireland, enacted the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (the Act). The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 places a legal requirement to undertake open disclosure for a list of 13 specific incidents. On the 19th October 2023, the Department of Health launched the National Open Disclosure Framework (2023).

It is expected that the Act will be commenced in summer 2024 and as set out in the Framework, healthcare providers will need to report on open disclosure to the Minister for Health in an annual report from 2025/2026 onwards.

The Patient Safety Act will also mean that there is now a specific law that limits the way in which information from clinical audits can be used. Freedom of Information legislation will not apply to information that is produced in clinical audit. This new law will also mean that information created during a clinical audit cannot be used:

- as evidence in legal cases (civil proceedings) against healthcare professionals,
- as evidence in disciplinary or fitness to practice procedures against healthcare professionals,
- as evidence to cancel a healthcare professionals insurance, or
- be used as an admission of fault by a healthcare organisation or professional.

We continue to develop and implement effective, person-centred incident management (IM) and open disclosure (OD) frameworks, policies, processes and procedures. In 2023, we partnered with a number of sites to implement Electronic Point of Occurrence Incident Reporting.

The Quality and Patient Safety Intelligence team developed and published a quality and patient safety "Data for Decision Making Toolkit" to assist committees, boards and leadership teams interested in developing their own quality agenda items.

Strategic Objective 7: Synergy, partnership and solidarity

Develop and sustain multisectoral and multinational synergy, partnership and solidarity to improve patient safety and quality of care

In September 2023, the National Quality and Patient Safety Directorate coordinated a Global Sepsis Summit in Dublin Castle. Its theme was 'Sepsis care in a post pandemic world'. The aim of the Summit was to raise awareness of sepsis in all settings, and provide a learning opportunity for all who attended, leading to better management and ultimately better patient outcomes for those who develop sepsis. A range of international speakers and delegates participated in this multinational safety-focused event.

The National Centre for Clinical Audit work in partnership with National Audit Service Providers to ensure a structured mechanism to commission a programme of work in clinical audit. Activities include approving national clinical audit, prioritisation, commissioning and ensuring alignment in terms of standards, delivery and communication. Examples include:

- A joint project, being piloted on the National Clinical Audit of Intensive Care Units - working with local clinical audit co-ordinators to build capacity and capabilities to increase quality improvements arising from the National Clinical Audit at each hospital site.
- In addition, the Quality and Patient Safety Improvement Team and National Centre for Clinical Audit are developing an approach to enable services to close the improvement loop following recommendations of National Clinical Audits. The Quality and Patient Safety Improvement Team is working with the National Clinical Programme for Stroke in Ireland, who are actively engaged in enhancing swallow screening rates for acute stroke patients in alignment with the recommendations of the National Stroke Strategy and the Irish National Audit of Stroke.

In 2023, the membership of the Q Community in Ireland rose to 153. Q Community is an ambitious, long-term initiative that brings together people working to improve health and care in 5 country partners across the UK and Ireland. It is led by The Health Foundation (UK) and the National Quality and Patient Safety Directorate administrates the programme and membership in Ireland.

In additional to strengthening our Patient Safety Community, 2023 saw the launch of our newsletter Patient Safety Matters #AllThingsQuality in April and the continuation of our QPSTalkTime webinar series, our Walk and Talk Improvement Podcast series, further development of our website and social media outreach to make information accessible to all. While the audience is predominately from the health service in Ireland, these resources are accessed by healthcare staff and patient partners globally.

The information in this document is a high level update and is not all encompassing. If you would like additional information on our programme of work, please do not hesitate to contact us.

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