



Patient Safety Strategy 2019-2024 Summary



Patient Safety Strategy 2019-2024: Introduction

Patient safety is a priority for both patients and our health care system. This Patient Safety Strategy was developed by patients and staff, working together to identify and implement improvements in healthcare that will support the provision of the safest and best care to those who need it.

The Strategy recognises that patients and those who use our mental health and disability services are often best placed to inform and support safety improvement and places a significant emphasis on patients being central to the planning and the implementation of the Strategy.

Why Patient Safety?

PREVENTABLE HARM

17%

of all hospitalisations are affected by one or more adverse events, with 30-70% potentially preventable.



PATIENT HARM estimated as **14th LEADING CAUSE** of global **DISEASE BURDEN.**



The 2009 Irish National Adverse Event Study indicated that an **adverse event** occurred in approximately **1 in 8** acute hospital admissions.

PREVENTABLE DEATH

In the UK an estimated **5.2%** of adverse events resulted in Patient Death.

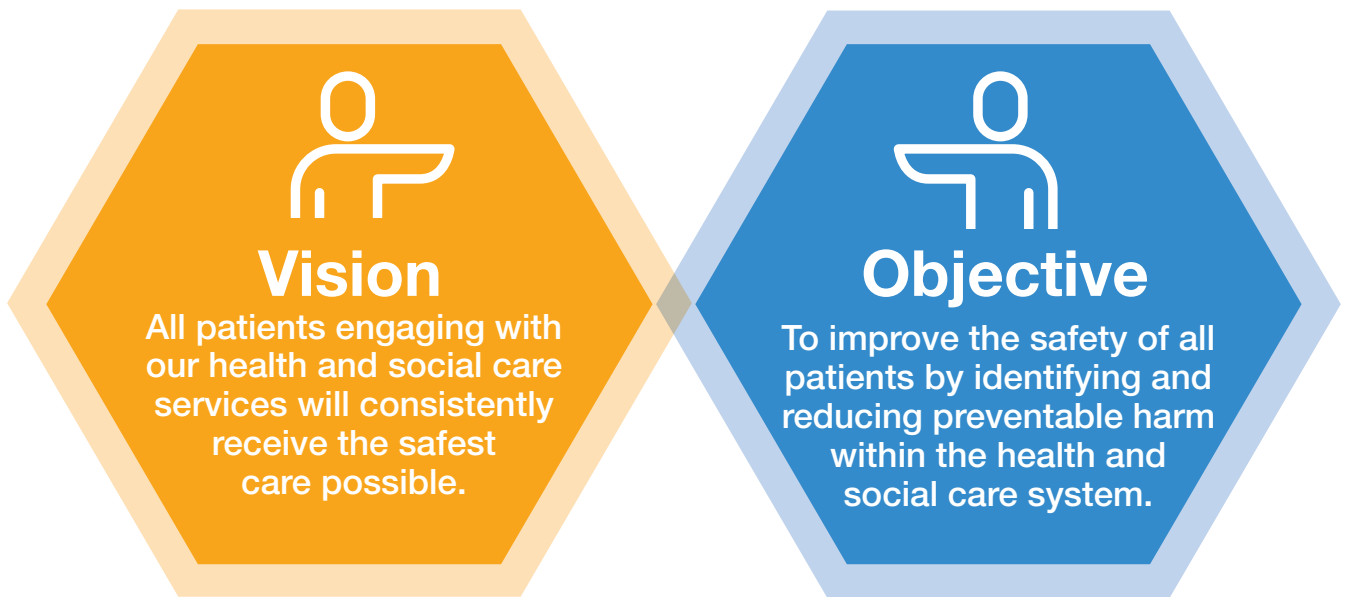


15% of **HOSPITAL EXPENDITURE** in OECD attributed to **TREATING SAFETY FAILURES.**

Total cost of clinical claims in **2010-2018** was **€1391.8 million.**

Patient Safety must be Everyone's Business!

Our Vision and Objective



Our Aims

- Ensure patients are partners in their care
- Promote an open and transparent culture of patient safety
- Learn from near misses and errors
- Identify and address the common causes of harm

Our Ambitions



Patient Safety Strategy: Our Commitments

1

Empowering and Engaging Patients to Improve Patient Safety

We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care.

2

Empowering and Engaging Staff to Improve Patient Safety

We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety.

3

Anticipating and Responding to Risks to Patient Safety

We will place an increased emphasis on proactively identifying risks to patient safety to create and maintain safe and resilient systems of care, designed to reduce adverse events and improve outcomes.

4

Reducing Common Causes of Harm

We will undertake to reduce patient harm, with particular focus on the most common causes of harm.

5

Using Information to Improve Patient Safety

We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.

6

Leadership and Governance to Improve Patient Safety

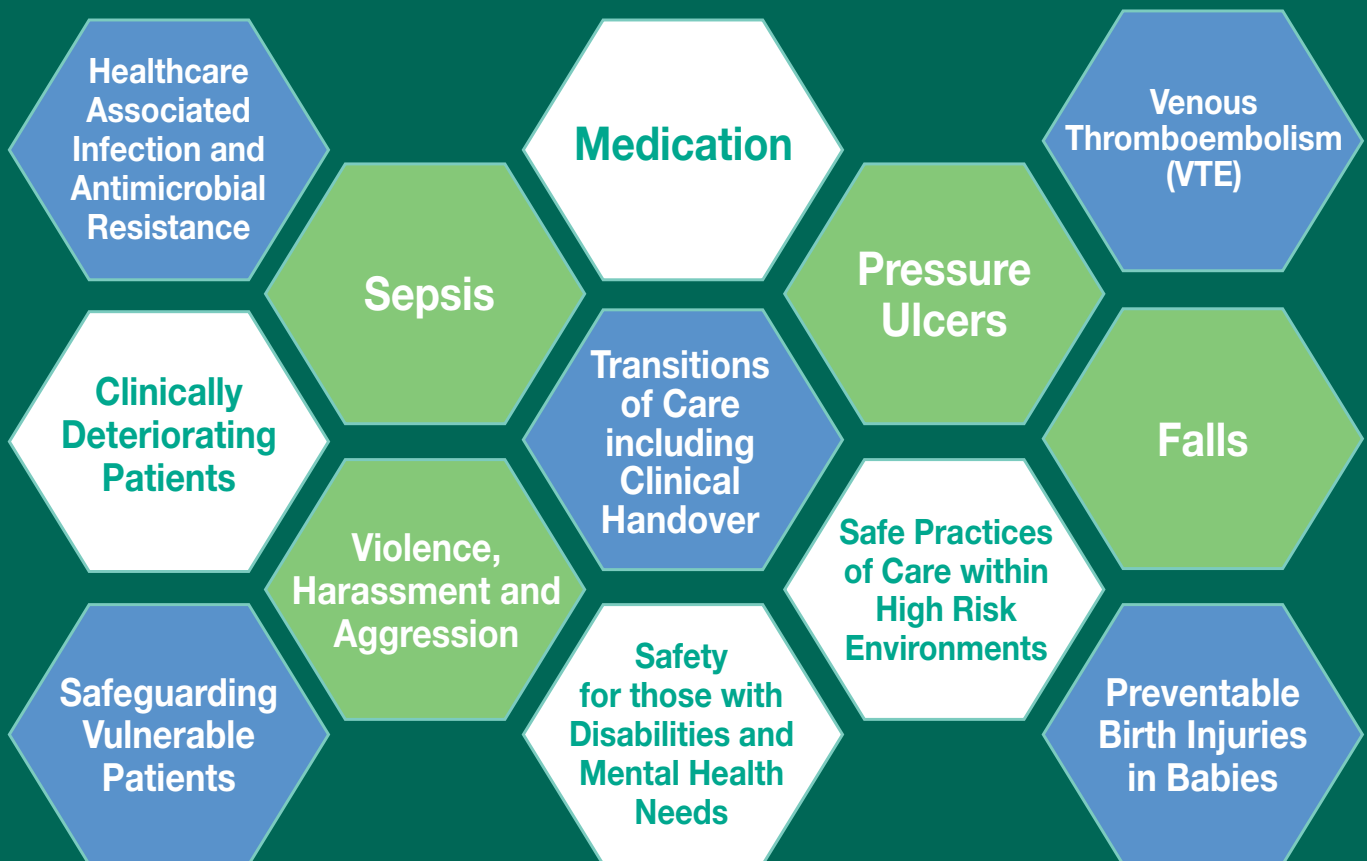
We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance.

Charter for Patient Safety



Patient Safety Improvement Priorities

This Strategy identifies a number of initial priority areas for reduction of harm and patient safety improvement:



In partnership with patients, we will constantly be reviewing our patient safety priorities to ensure that we are focussing our efforts on the areas that require it most.



A Strategy for Change

To support and monitor the implementation of the Strategy, a Patient Safety Programme and Team have been established. Patient Representatives will be involved at all stages of the Programme. Patient safety improvement actions will be contained in our National Service Plan and service level Operational Plans. The Patient Safety Programme Team will provide leadership, oversight, co-ordination and monitoring of the implementation of the Strategy.



For More Information:

Patient safety Programme Website
www.hse.ie/eng/about/qavd/patient-safety/

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