Patient Safety Strategy
2019-2024
Summary

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.

- **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.

- **Patient Safety must be Everyone’s Business!**

- **Total cost of clinical claims**
  - In 2010-2018 was €1391.8 million.
Our Vision and Objective

Vision
All patients engaging with our health and social care services will consistently receive the safest care possible.

Objective
To improve the safety of all patients by identifying and reducing preventable harm within the health and social care system.

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

For Patients
Patients have the information, knowledge, skills and supports to feel safe and contribute to and inform the development of safe and person-centred care.

For Staff
Staff have the information, knowledge, skills, environment, equipment, time and supports required to do their job, to work effectively with others for safety, to improve safety and to identify, implement and sustain new safety practices.

For Organisational Learning
We will actively promote, capture, share, spread and implement learning to improve patient safety throughout the health service.

For Systems
We have resilient and safe systems where there is a culture of meaningful measurement and improvement for safety with the patient at the centre.
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

**Strategy Commitments:**
The six commitments set out in the Strategy serve as a health service Charter for Patient Safety. We aim to embed these commitments at every level of the health service so that they serve as a basis for building a movement for patient safety.

**Strategy Actions:**
Each commitment comes with a set of associated actions. These actions are designed for adoption by local services. They recognise work already being taken, highlight further actions required, and they will be supported by the HSE nationally.

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Patient Safety Improvement Priorities

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

- Healthcare Associated Infection and Antimicrobial Resistance
- Venous Thromboembolism (VTE)
- Clinically Deteriorating Patients
- Sepsis
- Transitions of Care including Clinical Handover
- Violence, Harassment and Aggression
- Safeguarding Vulnerable Patients
- Medication
- Pressure Ulcers
- Safe Practices of Care within High Risk Environments
- Falls
- Preventable Birth Injuries in Babies
- Safety for those with Disabilities and Mental Health Needs

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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