Implementing the Patient Safety Strategy 2019-2024

National QPS Resource Guide

Prepared by the QPS Improvement Team,
National Quality & Patient Safety Directorate

Last updated: October 2022

Background & Purpose

Background

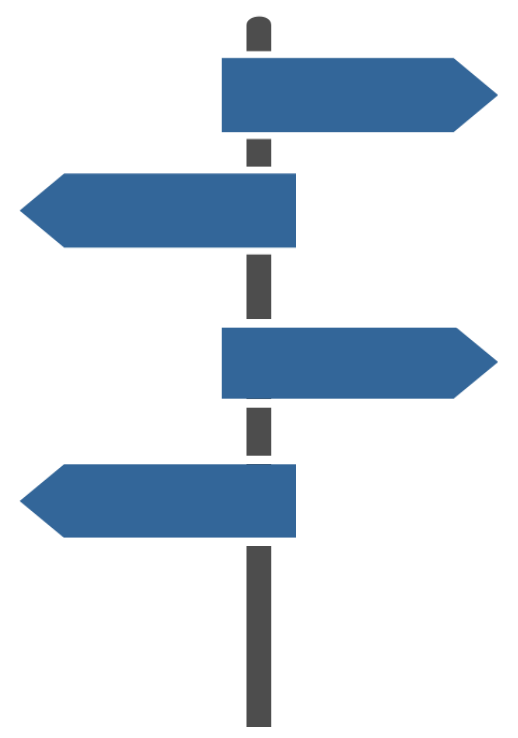
- The HSE Patient Safety Strategy 2019-2024 was launched in December 2019. It is the vision of the Strategy that all patients will consistently receive the safest care possible.
- The Strategy recognises the significant actions already taken to drive a culture of high quality and safe services, and seeks to build on and support this work. It outlines **6 Commitments** which serve as a health service Charter for Patient Safety, and **57 Strategic Actions** associated with those Commitments.
- The Strategy was developed primarily to guide further safety improvements at service level. It is recognised that this change cannot be centrally or nationally implemented; it can, however, be supported nationally. The HSE is committed to ensuring its national level resources are aligned to supporting continued local action for patient safety.

Background & Purpose

Purpose

The purpose of this document is to share key resources developed by the National Quality & Patient Safety Directorate with Health Service colleagues so they can use them to implement the HSE Patient Safety Strategy 2019-2024.

In this document, we signpost to resources that are available to access online. We also advise on training, initiatives, and support we can deliver with you and your team to support quality improvement initiatives and the implementation of the Patient Safety Strategy.



The National Quality & Patient Safety Directorate

The National Quality and Patient Safety Directorate works in partnership with HSE operations, patient partners and other internal and external partners to improve patient safety and the quality of care by:

- Building quality and patient safety capacity and capability in practice;
- Using data to inform improvements;
- Developing and monitoring the incident management framework and open disclosure policy and guidance;
- Providing a platform for sharing and learning; and
- Reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Directorate Teams

In line with the *Patient Safety Strategy 2019-2024,* the National QPS Directorate delivers on its purpose through the following teams:

1. QPS Improvement: Use of improvement methodologies to address common causes of harm identified in the Patient Safety Strategy
2. QPS Intelligence: Using data to inform improvements in quality and patient safety
3. QPS Incident Management: Incident Management Framework, Open Disclosure Policy & National Incident Management System
4. QPS Education: Enabling QPS capacity and capability in practice
5. QPS Connect: Communicating, sharing learning, making connection
6. Establishment and operation of the National Center for Clinical Audit

Tiered Model of Support to Services

National Quality & Patient Safety Directorate Tiered Model of Support

Tier	Tier Description	Model of Support	Examples of Support
Local Implementation	Signposting & support packages for local projects which are led through engagement with patients and frontline staff.	We have developed, and continue to develop, a range of QPS tools and resources to support local Patient Safety Strategy implementation and improvement projects across local care pathways.	• QPS Resource Guide and Improvement Toolkit • QPS Prospectus of Education and Learning Programmes • Foundational online training programmes in QI, Clinical Audit, and Human Factors • Library of Webinars & short videos e.g. "Making the most of your Safety Huddle" • Communication aids e.g. posters & infographics
Larger-scale Implementation	Tailored support for larger-scale projects delivered collaboratively within hospitals, hospital groups and/or CHOs.	Customised support to hospitals and/or community services to pursue a wider population approach, addressing specific Commitments of the Patient safety Strategy or Common Cause of Harm in partnership with existing programmes / models of care. Implementation is locally owned and nationally enabled.	• Tailored project clinics & webinars, bringing together subject-matter expertise with tried & tested approaches to QI and QPS • Blended training opportunities (online & face to face): for example, Improvement in Practice Programme, Open Disclosure, Incident Management, Human Factors, and Clinical Audit
Programmatic Implementation	Dedicated partnership with national clinical & integrated care programmes, across Hospital Groups and/or CHOs.	A range of supports to co-design and deliver wide-reaching improvements addressing multiple strategy commitments and actions across Hospital Groups and/or CHOs to mobilise resources and support delivery. Work towards sustainability, spread, and shared learning across the system	• Delivery of accredited postgraduate programmes to targeted clinical teams, building QPS capacity & capability • Coordination of subject-specific Collaboratives and Learning Sets to address highest patient safety priorities • Regular schedule of site visits and meetings to provide coaching and support

The National QPS Directorate has developed a tiered model of support to local, regional and national services, working in tandem with existing governance structures.

This model provides a structured and programmatic approach to supporting services to make improvements that address the Commitments, Actions and Common Causes of Harm identified in the HSE Patient Safety Strategy.

The model provides an effective and appropriate quantum of support to services, offering a consistent approach and managed expectations. It draws on the skills and expertise of the National QPS Directorate as a whole, as required, throughout a project.

Patient Safety Strategy – Strategy Resources

Click on the hyperlinks below to access the HSE Patient Safety Strategy as well as 2 supplementary resources which may assist services in implementing the Strategy.

Patient Safety Strategy
2019-2024

16 Top Tips for Patient Safety

1. Engage patients as partners in their care
2. Involve patients in the design, planning and delivery of our health service
3. Communicate clearly with patients about their care
4. Introduce yourself to patients and their family
5. Mind your personal health and wellbeing
6. Look out for colleagues who need support
7. Improve the culture of your workplace by practising Values in Action
8. Speak up if you see something unsafe
9. Create a secure environment for people to discuss their concerns
10. Recognise, highlight and build on existing good patient safety practice
11. Improve the quality and timeliness of incident reviews
12. Implement a learning culture to improve patient safety
13. Clean your hands properly to reduce risk of infection
14. Know about the common harms that happen in your clinical workplace
15. Keep good patient records and notes
16. Talk to patients about any changes to their medicines or care and implement the KnowCheckAsk campaign to enhance Medication Safety.

[The HSE Patient Safety Strategy 2019 - 2024]	[Top Tips for Patient Safety]	[Summary of the HSE Patient Safety Strategy]
Full document of the HSE Patient Safety Strategy	16 evidence-based tips for Patient Safety, which can help to improve patient safety and prevent adverse events from occurring in our health services.	A concise summary of the main tenets and ambitions of the Patient Safety Strategy.

Commitment 1

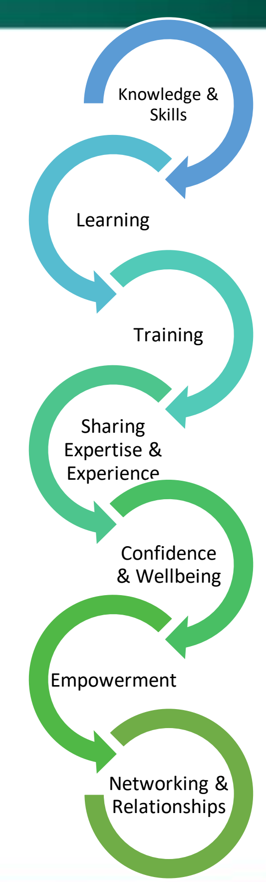
Empowering and Engaging Patients to Improve Patient Safety

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.

Involving Patient Partners in the National QPS Directorate

We are grateful to have patient partners involved in a number of our Directorate teams and projects. Benefits include:

1. The **voice of the patient is sought and heard**, keeping us grounded in the reality of how the system is really working from their / their group's perspective.
2. Management team meetings will provide an opportunity for patient partners to **share their perspectives to inform collective decision-making** in the Directorate.
3. **Meaningful engagement** is essential, and to be sought from the beginning, in order for the Directorate to develop a 'learning together' approach.
4. Patient partners to provide an **independent lens** through which patient safety initiatives are considered.
5. Opportunity for patient partners to **champion NQPS Directorate programmes** in patient forums.
6. Opportunity to **grow a patient partner network** that would offer capacity to engage in various work streams of interest.
7. Opportunity to **co-produce a resource pack** for future patient partners.



Resources for Empowering and Engaging Patients: Medication Safety

Document or resource type	Details	Links
“Know Check Ask” Campaign	Resources are available from our National Medication Safety Programme on the “Know Check Ask” Campaign. The campaign guides patients and healthcare professionals in understanding, knowing and keeping a list of medication to check details and discuss medicines with healthcare professionals and family. To promote this campaign in your place of work, see www.safermeds.ie for resources and information. We also have printed supplies of My Medicines Lists (A4 folded) as well as Know Check Ask and 5 Moments for Medication Safety posters (A3 posters). If you require these materials, please complete our online form at: https://www.smartsurvey.co.uk/s/SQKQCM/ and we will have these posted to you.	Click on the links below to learn more about the “Know Check Ask” campaign to help take medicines safely: • Download My Medicines list • Get Started • Get Involved • Resources

Resources for Empowering and Engaging Patients: Open Disclosure

Document or resource type	Details	Links
Information for Patients and Families: Open Disclosure Meeting	NATIONAL OPEN DISCLOSURE PROGRAMME ATTENDING AN OPEN DISCLOSURE MEETING Information for Patients and Families Open disclosure means that we will communicate with you in an open, honest, timely and transparent manner if: something goes wrong with your care; you experience harm as a result of your care; we think that harm may have occurred as a result of your care. An information leaflet has been developed for Patients & Families to help them understand and prepare for an open disclosure meeting, where necessary.	Patient Information Leaflet Open Disclosure: Information and Resources for the Public

Resources for Empowering and Engaging Patients: Incident Management – Toolkit for Developing Stories

Document or resource type	Details	Links
Toolkit for Developing Patient and Staff stories	The **NQPSD Office of Incident Management** offers services within the HSE and HSE funded services guidance in the development of their own patient and staff stories. This guidance document provides a standardised approach to the development of narrative and video stories The **Toolkit for Developing Patient and Staff Stories** offer real life examples, written from the perspective of patients as well as staff, which were kindly shared to support staff in the application of the principles outlined in the HSE's Incident Management Framework.	Incident Management Toolkit for Developing Patient and Staff Stories

Commitment 2

Empowering and Engaging Staff to Improve Patient Safety

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

Resources for Empowering and Engaging Staff: Education & Learning Programmes

Document or resource type	Details	Links
Prospectus of Education & Learning Programmes	Our recently launched QPS Prospectus of Education & Learning Programmes includes information about our learning and networking opportunities covering topics such as: • Serious Incident Management Team training • Systems Analysis Training • National Incident Management System (NIMS) Module 1 Training for Incident entry • National Incident Management System (NIMS) Module 2 Entering Incident Reviews • NIMS Reports, Views and Dashboard Training • Open Disclosure • Quality & Patient Safety Improvement • Clinical Audit • Human Factors • Schwartz Rounds • QPS Connections and Networking Opportunities	NQPSD Prospectus of Education and Learning Programmes For more information on QPS Education and Learning, email QPS.Education@hse.ie

Resources for Empowering and Engaging Staff: Human Factors in Healthcare

Document or resource type	Details	Links
Guide to Human Factors in Healthcare (2021)	The Introduction to Human Factors for Healthcare Workers was written for all healthcare workers. The primary aim is to provide an understanding of the principles and application of human factors and how it can be used to improve safety in healthcare. The Guide: 1. provides a comprehensive overview of human factors; 2. supports healthcare workers to identify the human factors issues in their workplace; 3. supports the identification of the human factors contributors to incidents; and 4. provides examples of human factors interventions that have been used in healthcare settings. Introduction to Human Factors e-learning programme and Foundation to Human Factors programme will go live in Q3 2022.	An Introduction to Human Factors for Healthcare Workers

Resources for Empowering and Engaging Staff: Quality Improvement Learning Programmes

Programme	Format	Provider
PG Cert in QI Leadership	10 month academic blended learning delivered by RCPI, funded by NQPSD	ROYAL COLLEGE OF PHYSICIANS OF IRELAND
Improvement in Practice	20 week blended learning	UNDER DEVELOPMENT
Foundation in Quality Improvement	3 hours e-learning	hseland.ie Cūram le Eolas
Introduction to Quality Improvement	30 min e-learning	hseland.ie Cūram le Eolas

Resources for Empowering and Engaging Staff: Quality Improvement Learning Programmes

Document or resource type	Details	Links
Postgraduate Certificate in QI Leadership in Healthcare	• **One year blended learning programme delivered over 10 months, Fully-funded for HSE employees** • Team and project-based learning programme designed to provide learners with knowledge and skills in aspects of QI, implementation science, patient safety and enhanced leadership capacity • CPD Eligibility: 72 CPD credits. Accredited through Quality Qualifications Ireland (QQI) as a level 9, 30 ECTS, Professional Certificate Programme on the National Framework for Qualifications. Graduates will receive a Postgraduate Certificate in Quality Improvement Leadership in Healthcare from RCPI.	RCPI PG Cert in QI Leadership **Applications for the current 2022 – 2023 Academic Year are now closed.**
Improvement in Practice	• **20 weeks blended learning programme, delivered by National QPS Directorate** • This 7 module Improvement in Practice Programme is delivered over a 20 week period and aims to develop the knowledge, skills and confidence of those actively involved in delivering patient safety improvements as part of a team. • This programme is commencing in Q4 2022.	TBD
Foundation in Quality Improvement	• **3 hours e-learning course, delivered on HSeLand** • The Level 1 Foundation in Quality Improvement programme will help you to develop an understanding and of the fundamentals of quality improvement in healthcare and will guide you in identifying the knowledge and skills you need to further your learning. • CPD eligibility: 8 CEU NMBI, 3 CPD external RCPI. CORU applicants can apply for credits through the CPD process.	The eLearning Programme is currently live on **HSeLanD**: 1. Go to www.hseland.ie 2. Create an account if you don't already have one (contact support@hseland.ie for any access issues) 3. Once logged in go to **Course Catalogues** 4. Enter the course title in the search bar function
Introduction to Quality Improvement	• **30 min e-learning course, delivered on HSeLand** • The Introduction to Quality Improvement will introduce individuals to the core concepts of quality improvement in healthcare and will help them think about how they can play an active role in improving quality and patient safety.	

Resources for Empowering and Engaging Staff: Quality Improvement Knowledge & Skills

Document or resource type	Details	Links
Quality Improvement Knowledge & Skills Guide	The purpose of this Guide is to support our health care services in their work to build their local Quality Improvement (QI) capacity and capability. Our 2021 publication is a revision of the 2017 guide, and includes new thinking and practices to strengthen our approach to QI education and learning. It articulates the six core competencies required for Quality improvement and the behaviours, knowledge and skills that align to these competencies. This Guide sets out a QI Learning journey where knowledge and skills are incrementally built upon as people choose to progress through the three levels of Learning. Within each level, knowledge and skills are set out against the six core competencies aligned to the HSE *Framework for Improving Quality*.	Quality Improvement Knowledge and Skills Guide

Resources for Empowering and Engaging Staff: Quality Improvement Terms and Concepts

Document or resource type	Details	Links
Quality Improvement Terms and Concepts	The Quality Improvement Terms and Concepts document is being developed as part of the “Improvement in Practice” programme. • Includes a collection of common terms and concepts used in the fields of Quality Improvement and Improvement Science in the Irish healthcare setting. • Collated from a wide variety of national and international resources. • Provides broad explanations of terms and concepts used in Quality Improvement work and provides links to additional information and resources. • A resource section has been provided as an appendix to support in-depth understanding of ow these terms and definitions relate to improvement in practice.	*Link to be included when document published* For more information on QPS Education and Learning contact: QPS.Education@hse.ie

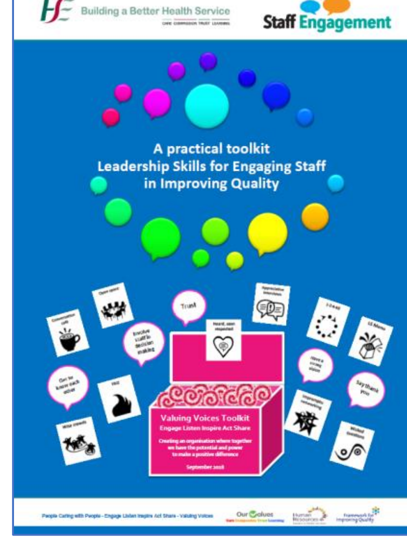
Resources for Empowering and Engaging Staff: Medication Without Harm online training

Document or resource type	Details		Links
Medication Without Harm online training		'Medication without Harm' is available as an online training module on HSELanD to all HSE staff. It takes approximately 1 hr 40 min to complete. The training covers the WHO global patient safety challenge, improving patient safety in transitions of care, with polypharmacy and with high risk medication. Training was developed by the Irish Institute of Pharmacy with the National Medication Safety Programme.	The eLearning Programme is currently live on **HSeLanD**: 1. Go to www.hseland.ie 2. Create an account if you don't already have one (contact support@hseland.ie for any access issues) 3. Once logged in go to **Course Catalogues** 4. Enter the course title in the search bar function

Resources for Empowering and Engaging Staff: Quality Improvement Toolkit

Document or resource type	Details	Links
Quality Improvement Toolkit	*We are updating our popular QI Toolkit at present* This QI toolkit contains 17 practical tools which can make carrying out a Quality Improvement project easier. The tools are appropriate for each of the four phases of the project, starting out with a 'light bulb' moment right through to the sustainability plan, where you are embedding the improvements you have achieved. There are some tools that you will find helpful for all projects and some tools may be more applicable to your project than others. Your line manager, local QI enthusiast or project sponsor may be able to help you when deciding which tools are relevant for your project.	Quality Improvement Toolkit

Resources for Empowering and Engaging Staff: Leadership Skills for Engaging Staff in Improving Quality

Document or resource type	Details		Links
Leadership Skills for Engaging Staff to Improve Quality: A Practical Toolkit		This toolkit was published in September 2018, in collaboration with the National Staff Engagement Forum and the Quality Improvement Division Staff Engagement Improving Programme. It is designed to give you ideas on how to start the conversation. You will find out more about engagement, some ideas on how to engage staff on organisational priorities and things that are important to them and guidance on where you can get more information. We hope it will support you in your work.	Leadership Skills for Engaging Staff to Improve Quality: A Practical Toolkit

Resources for Empowering and Engaging Staff: Schwartz Rounds

Document or resource type	Details	Links
Schwartz Rounds	**Encourages insight** • "Amazing insight into other professional's experiences" • "Felt glad that multidisciplinary from cleaner to consultant was emphasised" • " These rounds help break down barriers between all the different members of the hospital staff ..." • "Takes time out to my day to see the patients on my waiting list but is a good way to focus on caring for ourselves" **Reaffirms values** • "Brings caring and kindness back into the workforce" • "Helps us remember why we are in a caring profession" **Positive feeling** • "Feel-good factor - positive effect overall" • "Incredibly moving and human" • "Stunning - made me very proud to work with such compassionate, sincere and expert people" • "Well worth taking the time to attend despite a very busy schedule" **Highlighting important issues** • "Highlighted other issues like open disclosure" • "Very positive and potent reinforcement of how an individual can impact on patient care through non-clinical means - smiles, compassion, greetings" • "Very thought-provoking about what we do well and when things go wrong" NQPSD is working in collaboration with the Point of Care Foundation to establish Schwartz Rounds with organisations across Ireland. Schwartz Rounds are conversations with staff about the emotional impact of their work. They provide a valuable opportunity for all staff to reflect on their work through conversations facilitated by a local clinical lead and facilitator. They are unique in that, unlike other supports for staff, they do not seek to solve problems or look for outcomes. Schwartz Rounds are run monthly, and each round has a theme focussing on the human dimension of care. Three or four members of staff briefly tell a story about the theme. This is followed by a discussion facilitated by the Schwartz Rounds Clinical Lead and Facilitator which involves the wider audience and is an opportunity to listen, share and support, building mutual understandings. Follow us on twitter and engage in Schwartz Rounds conversations: @NationalQPS #QIreland #engaginghealthstaff #SchwartzRounds	HSE Schwartz Rounds Steps for introducing Schwartz Rounds 2021 Schwartz Rounds Information Leaflet Nov 2021 Evidence and benefits of Schwartz Rounds

Resources for Empowering and Engaging Staff: QPS TalkTime Webinars

Document or resource type	Details	Links
QPS Talktime Webinars	QPS TALKTIME Building an Irish Network of Quality improvers Live from National Patient Safety Office Conference, Dublin Castle Tuesday, October 11th at 1pm!! JOIN US • NQPSD provides a regular lunch time one hour webinar series focusing on improvement. Running approximately every two weeks, on Tuesdays from 1pm – 2pm • The webinars aim to connect people interested in QPS, and share learning & experiences of improvement. • Open to all those interested in improving quality and patient safety across our healthcare services. • Join individually or as a group to assist in building your own local QPS networks. • We have an exciting line-up for 2022, with a mixture of local, national and international speakers. • If you cannot join the webinars live, recordings and slide sets are available on our website for each session.	QPS Talktime

Resources for Empowering and Engaging Staff: Open Disclosure Webinars

Document or resource type	Details	Links
Open Disclosure Webinars	NQPSD provide regular staff webinars on Open Disclosure and related topics. The purpose of the webinars is to promote the HSE Open Disclosure Policy and the importance of Open Disclosure to patients, their families, staff and organisations. The webinars demonstrate how open disclosure is linked to the safety of patients and quality Improvement. They are open to all staff, patient representatives and patient advocacy services. You may join individually or as a group. All webinars attract CPD points. Recordings of the webinars are available on our website. To be added to our communication list about future webinars, email opendisclosure.office@hse.ie	Open Disclosure Webinars

Resources for Empowering and Engaging Staff: Open Disclosure Training and Education

Document or resource type	Details	Links
Open Disclosure Training and Education Resources for Staff	NATIONAL OPEN DISCLOSURE PROGRAMME OPEN DISCLOSURE E-LEARNING AVAILABLE ON HSeLanD Module 1 "Communicating Effectively through Open Disclosure" Module 2 "Open Disclosure: Applying Principles to Practice" Refresher training is required every 3 years. **<u>Open Disclosure training is mandatory for all staff.</u>** Training programmes available include: • E-learning Module 1:" Communicating Effectively through Open Disclosure" available on HSeLanD • E-learning Module 2: "Open Disclosure: Applying Principles to Practice" available on HSeLanD • Face to face skills training programme – contact the Open Disclosure Lead for your area • Open Disclosure Train the Trainer programme – contact the Open Disclosure Lead for your area **<u>Open Disclosure Resources:</u>** Numerous resources are available including the Open Disclosure Quick Reference Guide and Toolkit to support staff when engaging in open disclosure with patients and their families.	Information and Resources for Staff and Organisations: QPS Incident Management Open Disclosure Resources National Open Disclosure Leads: QPS Incident Management Open Disclosure Leads Information and Resources for Open Disclosure Trainers Information and Resources for Open Disclosure trainers

Resources for Empowering and Engaging Staff: Open Disclosure Staff Support Resources

Document or resource type	Details	Links
Open Disclosure Staff Support Resources	There are a number of resources available to support managers and staff following patient safety incidents. The **“ASSIST ME”** booklet was developed to provide practical information and guidance for health and social care managers and staff in relation to: (a) Understand the potential impact of patient safety incidents on staff (b) Recognise and manage the associated signs and symptoms (c) Support staff following patient safety incidents (d) Provide information on the support services available to staff The booklet provides helpful links to support services available in the HSE **Employee Assistance Programme, National Phone Line: 0818 327 327**	Open Disclosure Information and Resources on staff support National Open Disclosure Programme ‘Assist Me’ A Model of Staff Support following Patient Safety Incidents in Healthcare Open Disclosure ‘Assist Me’ staff support poster June 2021 EAP online hub of resources: www.hse.ie/EAPandME

Resources for Empowering and Engaging Staff: PATIENT SAFETY: learning, sharing and improving TOGETHER

Document or resource type	Details	Links
Patient Safety Together online resource	***PATIENT SAFETY: learning, sharing and improving TOGETHER*** is a freely available online resource that will enable all users to access and download new and up to date patient safety information. Resources will be shared within the new NQPSD website via a dedicated open access webpage. Learning direct from Patients/Service Users & Staff •**Safety Stories** - The aim of Safety Stories is to give a voice to the patients/service users and staff who have been involved or impacted by patient safety incidents. •**QPS Safety Community -** Exploring with a QPS working group how a Special Interest Group can support QPS Staff through the Q Community's Platform Learning from Incidents, Research & Data •**Patient Safety Alerts** (PSAs) - high priority communications in relation to patient safety issues, which requires HSE services and HSE funded agencies to take specific action(s) within an identified timeframe, in order to reduce the risk of occurrence or recurrence of patient safety incidents that have the potential to cause harm. • **Safety Supplements** - informs HSE and HSE funded agencies of timely and relevant quality and patient safety information for learning purposes. •**Signposting to Further Learning** including QPS academic papers, resources, conferences etc.	Coming Soon – Expected launch Autumn 2022

Resources for Empowering and Engaging Staff: Just Culture

Document or resource type	Details	Links
Incident Management Framework: Just Culture Guidance	The HSE strives for a Just Patient Safety Culture. The HSE Incident Management Framework (2020) defines Just Culture as one which refers to ***a values based supportive model of shared accountability.*** A Just Patient Safety Culture recognises that incidents can occur and that it is essential for staff to be able to report such events and feel psychologically safe to do so. Generally, incidents occur due to system failings rather than any individual working in the setting where the incident occurred. There is a balance to be achieved here however as deliberate or reckless acts that harm patients are not acceptable as they impact patient safety also. The Just Culture Guide helps managers have a dialogue as to whether or not a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. It applies a step-by-step sequential test: • Deliberate Harm • Health Test • Foresight Test • Substitution Test	Incident Management Framework Guidance 2020 Just Culture Guide Just Culture Overview Just Culture Summary Just Culture Assessment Framework

Resources for Empowering and Engaging Staff: Incident Management Framework Audit Tool v2

Document or resource type	Details	Links
Incident Management Framework Audit Tool v2	The IMF Audit Tool v2 is currently in development and aims to incorporate feedback received on v1 of the tool. Services can use the audit tool to assess compliance with the Incident Management Framework and the Open Disclosure Policy. The tool is offered as a support to services and includes a quality improvement plan template. Once all feedback has been incorporated, v2 will be tested and a user guide developed to accompany the tool.	Coming Soon

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Return to Overview page

Completed for Categor

Current audit in progre

Scroll down for your form or use the buttons provided here to navigate

Audit period 1 | Audit period 2 | Audit period 3 | Audit period 4 | Audit period 5

Audit period 1

Return to Overview page

Hospital Group/CHO

Hospital/Service

Auditor(s)

Initial Date of Audit

Final Date of Audit

For each incident included in the audit identify if there is documentary evidence that:

	Incident No:	1	2
	Section 1: identification and reporting		
1	At the time of occurrence, the incident was documented in the healthcare record of the person affected?	Yes	s
2	The immediate actions required to manage any harm to the person affected were documented in the healthcare record of the	Yes	Yes
3	The SAO was notified of this incident within 24 hours of occurrence.	Yes	Yes
4	If this incident is an SRE that it was identifed as an SRE on NIMS?	Yes	Yes
5	The service assigned a named designated person to support the person harmed/family	Yes	Yes
6	The service assigned a named designated person to support staff impacted by the incident	Yes	Yes
7	The service carried out Open Disclosure in line with HSE policy	Yes	Yes
8	The salient points of the Open Disclosure meeting were recorded in the service users clinical/care record	No	No
	The incident was reported on NIMS within 24		

Overview | Improvement Plan | Data Categ1 | Data Categ2

Commitment 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.

Resources for Anticipating and Responding to Risks: Incident Management

Document or resource type	Details	Links
Incident Management Resources for Staff	In addition to Training for Incident Management (see the QPS Prospectus referenced earlier), there are a range of resources available for staff. 2020 Incident Management Framework Care | Compassion | Trust | Learning 2020 Incident Management Framework – Guidance Care | Compassion | Trust | Learning	Information and Resources for Staff and Organisations: NQPSD QPS Incident Management

Resources for Anticipating and Responding to Risks: National Centre for Clinical Audit (NCCA)

Document or resource type	Details	Links
NCCA Nomenclature - A Glossary of Terms for Clinical Audit	HSE National Centre for Clinical Audit **Nomenclature** A Glossary of Terms for Clinical Audit The **2019 HSE National Review of Clinical Audit** identified inconsistencies in the language used across the Irish Healthcare system in clinical audit The purpose of this Nomenclature document is to provide a glossary of agreed terms, including a standard definition for clinical audit, to be adopted across all healthcare services and clinical audit service providers. This guidance is intended to strengthen clinical audit in Ireland and assist those carrying out clinical audits across Ireland through the provision of an agreed glossary of terms. Ionad Náisiúnta d'Iniúchadh Cliniciúil An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar National Centre for Clinical Audit National Quality and Patient Safety Directorate	HSE National Review of Clinical Audit Report 2019: National review of clinical audit report 2019 Nomenclature - Glossary of Terms for Clinical Audit: Nomenclature glossary of terms for clinical audit

Resources for Anticipating and Responding to Risks: National Centre for Clinical Audit (NCCA)

Document or resource type	Details	Links
NCCA Range of Clinical Audit Training programmes	HSE National Centre for Clinical Audit Training Programme 2022 In partnership with Clinical Audit Support Centre (CASC) HSE National Centre for Clinical Audit The NCCA has developed Clinical Audit Training developed in collaboration with the Clinical Audit Support Centre (CASC) in the UK. It includes the Fundamentals in Clinical Audit Course and an Advanced Course in Clinical Audit • The Fundamentals in Clinical Audit Course is delivered either via elearning OR virtually over one full day and one half day • The Advanced Clinical Audit is delivered virtually over one day. • The training is interactive and provides a wealth of educational resources and further signposting. • To further develop skills 'The Train the Trainer in Clinical Audit' course will be in-person, classroom based and offered to staff.	**NCCA Training Programme 2022:** HSE National Centre for Clinical Audit training programme 2022

Resources for Anticipating and Responding to Risks: National Centre for Clinical Audit (NCCA)

Document or resource type	Details		Links
NCCA Fundamentals in Clinical Audit E-Learning Programme	Fundamentals in Clinical Audit National Centre for Clinical Audit National Quality and Patient Safety Directorate 0 Reviews The course is designed to assist all staff to gain a good understanding of the fundamentals in clinical audit with the aim of enabling them to undertake their own successful clinical audit project. The course is highly interactive. All learners work through four modules: 1. A brief history of clinical audit and why you should get involved 2. Defining clinical audit and the clinical audit process 3. In-depth review of the stages of the clinical audit process 4. Assessment and signposting By undertaking the course, learners will understand why clinical audit is important and where it fits into their work. Learners will understand the seven steps involved in carrying out a clinical audit project, relevant to their own work. Upon working through all four course modules, learners will be able to conduct a clinical audit relevant to their work. Learners will also gain the necessary skills to be able to effectively support others conducting clinical audit projects. Learning Type: Online Available Languages: • Multi-Language Duration: The programme is assessed as 10 hours of learning. Who Should Take This: • This programme is designed for anyone who wants to gain a better understanding of clinical audit and will suit those with no, minimal or some experience/familiarity of the subject matter. Objectives: • Description	Fundamentals in Clinical Audit E-Learning Programme is available now via HSeLand. The course is designed to assist staff to gain a good understanding of the fundamentals in clinical audit with the aim of enabling them to undertake their own successful clinical audit project.	The eLearning Programme is currently live on HSeLanD: 1. Go to www.hseland.ie 2. Create an account if you don't already have one (contact support@hseland.ie for any access issues) 3. Once logged in go to **Course Catalogues** 4. Enter ***Fundamentals in Clinical Audit*** in the search bar function

Commitment 4

Reducing Common Causes of Harm

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

Common Causes of Harm: Patient Safety Priorities

International evidence indicates there are a small number of high impact patient safety risks, which, if tackled effectively, can result in improving safety and quality in healthcare organisations. Considering this evidence, 13 patient safety priority areas, referred to as "common causes of harm" have been identified in the Patient Safety Strategy. These are outlined in the figure below:

Addressing the Common Causes of Harm: Reducing Medication Related Harm

Document or resource type	Details	Links
iSIMPATHY: Ensuring the best and most sustainable outcomes with medication use in patients taking multiple medicines	iSIMPATHY Medicine Reviews and the 7 steps approach RIGHT MEDICINE? UNNECESSARY MEDICINE EFFECTIVE MEDICINE? HARMFUL MEDICINE COST EFFECTIVE MEDICINE AGREE AND SHARE MEDICINE PLAN WHAT MATTERS? • The NQPSD National Medication Safety Programme is a key partner in the EU funded iSIMPATHY project in Northern Ireland, Scotland and the Republic of Ireland, delivering safety focussed, person centred medicines reviews in primary care. • Over 1750 reviews have been delivered by 4 pharmacists working with 10 GP practices from Jan 2021 to end July 2022. The project continues to March 2023. • The reviews and approach are highly acceptable to patients and GPs. • Reviews result in a mean reduction of two medicines and addressing a mean of one high risk polypharmacy indicator and 13 issues in total per review. • There are a range of resources available online for patients, healthcare professionals and clinicians.	https://www.isimpathy.eu/about Interim analysis of the iSIMPATHY project in the Republic of Ireland, April 2022: https://www.lenus.ie/handle/10147/631776

Addressing the Common Causes of Harm: Recognising, Reducing and Managing VTE

Document or resource type	Details	Links
VTE Clinical Guidance, Patient Alert Cards and Posters	For more information: www.thrombosis.ie BLOOD CLOT ALERT CARD WHAT IS A BLOOD CLOT? This is the formation of a clot inside a blood vessel, usually in the leg, which may break off and go to the lungs. This can be fatal. 60% of clots happen in HOSPITAL or in the 90 DAYS following admission Blood clots can be very serious - but there are effective treatments to deal with them and help prevent them SIGNS AND SYMPTOMS OF A BLOOD CLOT → Swelling or pain in one leg or calf → Warmth or redness in the leg → Short of breath or rapid breathing → Chest pain (particularly when breathing deeply) → Coughing or coughing up blood If you have one or more of these, you may have a clot and need urgent treatment Thrombosis Ireland CSN: 20154240 Building a Better Health Service BLOOD CLOT ALERT CARD Am I at risk? WHAT CAN I DO TO HELP MYSELF? → Ask for your risk of blood clots to be assessed, especially if you are in one of the higher risk groups listed opposite → Walk and move as much as possible → Drink plenty of fluids → If directed to use stockings or medication to prevent or treat a clot follow instructions exactly → Remember, a clot can form up to 90 days after being in hospital → If you have any signs or symptoms of a clot, take **Immediate action** to seek medical help HOSPITAL AEROPLANE! YOU MAY BE AT HIGHER RISK IF YOU: → are admitted to hospital and for 90 days after you go home → have active cancer or receiving cancer treatment → are pregnant or have had a baby less than 6 weeks ago → become immobile (more than 3 days in bed / travel non-stop more than 6 hours / in a leg cast) RISK MAY INCREASE FURTHER IF: → you or a close relative had a blood clot → you had surgery in the last 90 days → you have thrombophilia (tendency to clot) → you are on the oral contraceptive pill or HRT → you have heart, lung or inflammatory disease → you are over 60 years of age or are overweight → you have varicose veins that become red and sore • Covid-19 Interim Clinical Guidance – VTE Protocol and Patient Information for Acute Hospitals (D19-120-001 04.05.22) https://hse.ie.libguides.com/c.php?g=4866382 • VTE patient alert cards and posters including 'Ask for Alert Cards' and 'Blood Clots – am I at risk?' www.Safermeds.ie and follow links to VTE (blood clot) information for patients and healthcare professionals.	Visit www.Safermeds.ie and refer to VTE (blood clot) information links.

Addressing the Common Causes of Harm: Reducing Pressure Ulcers

Document or resource type	Details	Links
Pressure Ulcers to Zero (PUTZ) Collaboratives	The National QPS Directorate has experience in delivering Pressure Ulcers to Zero (PUTZ) Collaboratives, and we have a repository of virtual resources (e.g. case studies, presentations, webinars, templates, and tools) to support teams undertaking PUTZ improvement projects. • A collaborative is a short-term (6 to 15-month) learning system that brings together several teams from healthcare settings to seek improvement in a focused topic area. • The primary aim of PUTZ was to reduce the number of avoidable pressure ulcers across participating teams by 50% within the time frame of the collaborative and to increase the capacity and capability of frontline clinical teams to improve the care they deliver. The Collaborative also supports participating teams in using QI approaches and developing and improving knowledge, skills and expertise in pressure ulcer prevention. • Although PUTZ Collaboratives were paused in 2020 due to the COVID pandemic, work continued in the background in 2020 & 2021 to evaluate outcomes and demonstrated that the PUTZ 4 Collaborative (2019 – 2020) achieved a 70.4% reduction in acquired pressure ulcers in both hospital and community teams.	NQPSD Patient Safety Pressure Ulcers to Zero (PUTZ)

Addressing the Common Causes of Harm: Pressure Ulcers - A Practical Guide for Review

Document or resource type	Details	Links
Pressure Ulcers - A Practical Guide for Review	NQPSD has guidance documents offering service providers a practical guide for review of Pressure Ulcers including assessment forms and report template This documents should be read in conjunction with the HSE Incident Management Framework The documents include: • Pressure Ulcers - A Practical Guide for Review • Pressure Ulcer Review - Preliminary Assessment Form • Pressure Ulcer Review - Report Template	Pressure Ulcers - A Practical Guide for Review Pressure Ulcer Review - Preliminary Assessment Form Pressure Ulcer Review - Report Template

Addressing the Common Causes of Harm: Reducing the Risk of Harm from Falls

Document or resource type	Details	Links
Review of Service User Falls Incidents	NQPSD has guidance documents offering service providers a practical guide to reviewing service user falls, including related assessment forms and templates. These documents should be read in conjunction with the HSE Incident Management Framework The documents include: • Service User Falls - A Practical Guide for Review • Service User Falls Review - Preliminary Assessment Form • Service User Falls Review - Report Template	Service User Falls - A Practical Guide for Review Service User Falls Review - Preliminary Assessment Form Service User Falls Review - Report Template

Addressing the Common Causes of Harm: Reducing the Risk of Harm from Healthcare Associated Infections

Document or resource type	Details	Links
Review of Healthcare Associated Infection Incidents	NQPSD has guidance documents offering service providers a practical guide to reviewing healthcare associated Infections including related assessment forms and templates. These documents should be read in conjunction with the HSE Incident Management Framework The documents include: •Procedure on the use of Review Tools (RT) for healthcare associated infections •Hospital Acquired Infection Review Tool •Hospital Acquired Staphylococcus Aureus Blood Stream Infection Review Tool •Severe Hospital Associated Clostridioides Difficile Infection Review Tool	The following tools can be found on the link below: • Procedure on the use of Review Tools (RT) for healthcare associated infections. • Hospital Acquired Infection Review Tool • Hospital Acquired Staphylococcus Aureus Blood Stream Infection Review Tool • Severe Hospital Associated Clostridioides Difficile Infection Review Tool: Incident management - HSE.ie

Commitment 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.

Using Information to Improve Safety: Measurement for Improvement

Document or resource type	Details	Links
Effective Measurement Framework	**The Seven Steps to Effective Measurement for Improvement** 1 Is there an Opportunity to Improve? — ➢Does your available data suggest there is a need for improvement? ➢Do Subject Matter Experts have a hunch that there is a problem or have an idea for improvement? 2 Choose Measures — Ensure your measures: ➢measure what you intend ➢ produce data which can indicate whether an improvement has occurred ➢ are the vital few measures you need to achieve your aim 3 Plan Measurement — Your measurement plan should: ➢Specifically define what you are measuring and how to measure ➢Include both quantitative and qualitative measures where appropriate 4 Collect Data — Use data collection systems that are already in place if appropriate ➢Be consistent so that everyone records/collects data in the same way ➢ Use baseline data where possible 5 Analyse & Display Data — ➢Data analysis must be conducted on both quantitative and qualitative data ➢ Carefully consider the most appropriate way to analyse and display your data. For example, an SPC chart identifies non-random variation ... 6 Interpret & Present Findings — ➢Review findings with Subject Matter Experts to include their insights in interpretation ➢ Presented to the right audience who are willing to receive it 7 Act on Findings — ➢Implement changes to address the areas which have been identified as in need of improvement/ which has been shown to be effective ➢Identify further areas of improvement This document outlines the 7 steps and associated tasks to generate and use data effectively for improvement. It offers an effective measurement framework, and is helpful to ensure you don't forget any key steps in the process	7-steps-effective-measurement-framework

Using Information to Improve Safety: Analysing and Presenting Data

Document or resource type	Details	Links
Tools for Analysing and presenting data	The QPS Intelligence Team has developed an automated Excel template for 8 commonly used types of SPC charts. • All calculations are automated. • User only needs to copy-paste data and select type of graph. • The template calculates the graph and displays special cause applying the rules and visualisations developed for HSE reports. • The template highlights the rules applied and rationale for special cause variation points: • Intro page and demo videos available as support materials	Excel Template for 8 SPC charts Demo video

Using Information to Improve Safety: Developing a Quality Profile

Document or resource type	Details	Links
Developing a Quality Profile	HSE Quality Profile March 2021 Quality Indicators Safe: Hospital acquired new cases of S. aureus bloodstream infection per 10,000 bed days used; Hospital acquired new cases of C. difficile infection per 10,000 bed days used Effective Person-centred: Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration Timely: Percentage of new patients attending rapid access breast, lung & prostate clinics within recommended timeframe; Percentage of people waiting <13 weeks following a referral for routine colonoscopy or OGD; Hip fracture surgery within 48 hours Efficient: Weekly number of delayed transfers of care; Day of surgery admission rate Equitable: Disability Act compliance: percentage of child assessments completed within the timelines as provided for in the regulations Better Health & Wellbeing: MMR vaccination rate Organisations may use different names to describe their Quality Profile such as Quality Report, Quality and Safety Profile, Quality Scorecard or Dashboard. Whatever the name, it looks at trends over time and across the system to understand the quality performance of the organisation and to drive and demonstrate improvement. • Introduction to Quality Profile: This document introduces you to the principles and purpose of the Quality Profile. • Quality Profile Development Flowchart: Summarises the 7 key steps that your QI Project Team should go through when developing your Quality Profile. • Quality Profile aligned to the themes of the National Standards for Safer Better Healthcare This document provides measures that are commonly used as indicators of quality of care and are often used as KPIs. • Examples of local measures that may be used in a Quality Profile aligned to the themes of the National Standards • Quality Profile recommended Reading List can support you when developing and implementing your Quality Profile. • You can see Quality Profiles produced for the HSE Board on the Reports Page	Introduction to Quality Profile: QPS intelligence resources - HSE.ie Quality Profile Development Flowchart : QPS Intelligence – Profile Development Flowchart Quality Profile aligned to the themes of the National Standards: QPS Intelligence – Themes of national standards for safer better healthcare Examples of local measures that may be used in a Quality Profile: QPS Intelligence - Examples of local measures that may be used in a Quality Profile Quality Profile Reading List: recomended-reading-list.pdf (hse.ie) Quality Profiles produced for the HSE Board: QPS intelligence reports - HSE.ie

Using Information to Improve Safety:
Using Surveys and Qualitative Methods in QI projects

Document or resource type	Details	Links
Tools for using surveys and qualitative methods in QI Projects	The QPS Intelligence Team has developed a range of tools to help guide teams in using surveys and qualitative methods in QI projects: • Introduction to qualitative methods: This presentation covers what Qualitative Research is and the differences between qualitative and quantitative approaches to research and evaluation, including methods such as interviewing, focus groups, observation and documentary analysis and briefly addresses approaches to analysing qualitative data • Guidance on how to use and analyse surveys: Surveys are an effective way to quickly gather information and data when you are seeking feedback on a particular topic, fact and information about people or their knowledge, attitudes or opinions about something. This document offers guidance on designing, conducting, analysing and presenting surveys.	Guidance on how to use and analyse surveys Introduction to qualitative methods

Using Information to Improve Safety: QI Self-Evaluation Guide and Workbook

Document or resource type	Details	Links
QI Self-Evaluation Guide and Workbook	**Is self-evaluation appropriate?** There are different ways you can evaluate your work and the following decision tree will help you to decide whether self-evaluation is appropriate for your project. Do I want to know if and/or how my project worked? Yes No Are the QI project measures/other available measures enough to tell me what I want to know? No Yes Is learning from my project a strategic priority for the National QI team? No additional self-evaluation required Yes No Conduct evaluation – but what type? • Is an independent perspective required for the evaluation to be accepted and used system-wide? • Is the budget and/or capacity likely to be made available for commissioning and managing an external evaluation team? • The necessary skills and capacity to conduct the evaluation are not available internally? Are most of your responses 'No'? Are most of your responses 'Yes'? Conduct self-evaluation Consult with HSE PMO re. potential for internal evaluation Commission independent evaluation The QI guide for self-evaluation and accompanying workbook were developed by team members of the National QPS Directorate. They include templates and other useful tools to inform your decision-making about your evaluation project. The templates have been partially completed, using the Directorate project as an example, to show how the tools and templates can be used. Blank templates are also included in the workbook, and it is intended that you should complete the templates included in planning the evaluation of your project.	QI Self-Evaluation Guide QI Self-Evaluation Workbook

Using Information to Improve Safety: National Incident Management System (NIMS)

Document or resource type	Details	Links
Integrated guide to NIMS reporting for assurance and data quality improvement	The National Incident Management System (NIMS) is an end to end incident management system developed to improve patient and service user safety. The system supports staff to carry out and report on reviews into incidents, the monitoring of recommendations from such reviews and provides rich data which can inform services of any incident trends or new risks. To help improve the Data Quality on NIMS there is a specific working group focused on Data Quality. The HSE NIMS colleagues are working on a number of engagement and communication pieces to keep users informed about the system. NIMS data is also used to inform the National Service Plan KPIs. The ***Integrated guide to NIMS reporting for assurance and data quality improvement was developed to*** outline how the data is extracted from NIMS at national level. It will allow services to apply the same methodology and ensure consistency when the data is pulled at local level for data validation and monitoring purposes. A webinar was held and recorded to demonstrate how the Guide can be applied (Youtube link) The **HSE NIMS helpdesk** is available to help HSE and HSE-funded healthcare providers with their enquiries in relation to NIMS. The enquiries can relate to: - Technical enquiries - Clinical reporting enquiries - NIMS Location enquiries - Data Services Enquiries - Report enquiries	National incident management system (NIMS) - HSE.ie NIMS webinar – YouTube NIMS helpdesk at nims@hse.ie

Using Information to Improve Safety: National Incident Management System (NIMS)

Document or resource type	Details	Links
NIMS Electronic Point of Entry Guidance Document	We are rolling out the electronic point of entry reporting system whereby staff can report directly onto NIMS and we have developed many resources to support staff with this project: **<u>NIMS Electronic Point of Entry</u>** The NIMS Electronic Point of entry guide provides services with relevant information about adapting direct incident reporting onto NIMS. Electronic point of entry reporting is where frontline staff enter incidents directly onto the National Incident Management System eliminating the need for paper reporting. The ePOE guidance document contains the following resources: • NIMS ePOE Guide for Local Implementation • NIMS FAQ ePOE • Healthcare Incident Hazard Quick Reference Guide • NIMS Picklist • NIMS Sample Project Task List Template • NIMS Sample Project Charter Template	Link ePOE infographic and guidance documents: National incident management system (NIMS) - HSE.ie

Using Information to Improve Safety: INAES-2 Tool

Document or resource type	Details	Links
Irish National Adverse Events Research (INAES-2) Tool	ORIGINAL RESEARCH OPEN ACCESS **The Irish National Adverse Event Study-2 (INAES-2): longitudinal trends in adverse event rates in the Irish healthcare system** Warren Connolly,[1] Natasha Rafter,[2] Ronan M Conroy,[2] Cornelia Stuart,[4] Anne Hickey,[5] David J Williams[1] BMJ The second Irish National Adverse Events Research study (INAES-2) was published in 2021. This research presents the prevalence and nature of adverse events in acute hospitals and is a valuable benchmark for Patient Safety research in Ireland. NQPSD and RCSI are collaborating on producing a tool that will be available to clinicians and staff that wish to replicate the INAES-2 methodology in their own service for the purposes of learning and improvement.	Coming soon

Using Information to Improve Safety: QPS Research

Document or resource type	Details	Links
Research Collaborative in Quality & Patient Safety (RCQPS)	RCQPS Research Collaborative in Quality and Patient Safety HSE • HRB • RCPI The Research Collaborative in Quality and Patient Safety (RCQPS) was a collaborative initiative between the Health Research Board, the HSE National QPS Directorate, and the Royal College of Physicians of Ireland. It was established in 2013 to advance nationally relevant research in the area of quality and patient safety (QPS). There were 18 research awards between 2013 – 2021. These projects are excellent examples of collaborations between academic researchers, knowledge users and patients working together to achieve translatable findings for improvements in the quality of care.	For more information on the RCQPS and completed research which may be of interest, please see https://www.rcpi.ie/research/research-collaborative-in-quality-and-patient-safety/

Commitment 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.

Connecting for QPS Leadership: Q Community

Document or resource type	Details	Links
Apply to become a Q Community Member via NQPSD	• The Q Community is an initiative connecting people who have health improvement expertise across the five countries of the UK and Ireland, with over 4,500 members. • Ireland's participation is coordinated and driven by the QPS Connect Team in NQPSD. There are currently 111+ Q members in Ireland. Members of the NQPS Directorate participate in bi-monthly video calls with Q Country partner leaders to share experiences, learning, and consider how best to accelerate the use of QI knowledge and skills across each member country. Lab workshop: 5 December Birmingham Peer support workshop in Northern Ireland What does peer support mean to you? Together, to improve health and care	Apply online at: https://q.health.org.uk/

Connecting for QPS Leadership: QPS Ireland Network Map

Document or resource type	Details	Links
Join the NQPSD QPS Ireland Network Map	• The QPS Ireland Network Map aims to visualise and build the connections of those who are involved and interested in healthcare quality improvement in Ireland. • Your participation in the map is entirely voluntary and is based on your specific and informed consent. You can withdraw at anytime by deleting your data on the map. • Please note the links to view the maps are live i.e. when you join the map or update your information – the embedded maps will update instantly.	QPS Ireland Network Map - HSE.ie To opt in to join the map: 1. Enter your details here. 2. You will then be sent a unique link to a short survey (in SumApp) where you can add information to be shown about you on the map. 3. You are also invited to select from the map, the people that you are already connected with and indicate your connection type (constant, frequent, occasional).

Quality Improvement for Leadership: Supporting Healthcare Boards

Document or resource type	Details	Links
NQPSD QI Resources for Healthcare Boards	The National QPS Directorate Governance for Healthcare Boards Programme supports quality and safety as a core function at the heart of the health services by : • Supporting the board in developing Core Board Processes to oversee all dimensions of quality and to assess their progress over time • Developing and delivering a National Boards Quality and Patient Safety & Governance self-assessment tool and board resources. • Supporting the roll out and implementation of a Quality and Safety Walk-round training programme. • Delivering board masterclasses and learning sets with healthcare board members, to support the board's knowledge and skills. • Evaluating and testing a number of new ways of Boards engaging with patient and staff on their experience of quality at HSE board level. • Testing and adapting the board a 'picture of quality' that supports a board in its role in leading improvement in quality and safety e.g. A Board Quality Profile with prioritised measures.	A Board's Role in Improving Quality and Safety - Guidance and Resources Quality and Safety Walk-rounds: A Co-designed Approach - Toolkit and Case Study Report Quality & Safety Committees: Guidance and Resources

National Quality and Patient Safety Directorate

Office of the Chief Clinical Officer

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Additional Resources:
Recently Published Research by NQPSD team members

Topic area	Citation and Link
Describes the establishment and first year of a national Contact Management Programme (CMP) in Ireland (2022)	An overview of the establishment of a national contact tracing programme: a quality improvement approach in a time of pandemic Martin J, Carroll C, Khurshid Z, et al. An overview of the establishment of a national contact tracing programme: a quality improvement approach in a time of pandemic. HRB Open Res; 2022. DOI: 10.12688/hrbopenres.13484.1.
QI approach to supporting Boards in developing a new way of looking at quality (2022)	Board level 'picture understanding action a new way of looking at quality' Martin, J., Flynn, M.A., Khurshid, Z., Fitzsimons, J.J., Moore, G. and Crowley, P. (2022), "Board level "Picture-Understanding-Action": a new way of looking at quality", International Journal of Health Governance, Vol. 27 No. 1, pp. 105-117. https://doi.org/10.1108/IJHG-05-2021-0047
Rapid evidence review on delivering QI training and education using distance learning modalities (2021)	Virtual adaptation of traditional healthcare quality improvement training in response to COVID-19: a rapid narrative review. Khurshid, Z., De Brún, A., Moore, G. *et al.* Virtual adaptation of traditional healthcare quality improvement training in response to COVID-19: a rapid narrative review. *Hum Resour Health* **18**, 81 (2020). doi: 10.1186/s12960-020-00527-2

Additional Resources:
Recently Published Research by NQPSD team members

Topic area	Citation and Link
Systematic review to define effectiveness and sustainability of QI programmes for health care professionals containing a measurement skills component and to identify barriers and facilitators to effectiveness and sustainability (2021)	A Systematic Review and Narrative Synthesis. Determinants of the Effectiveness and Sustainability of Measurement-Focused Quality Improvement Trainings. Khurshid, Zuneera BBA (HONS), MBA; De Brún, Aoife BA(Hons) Psychology, PhD; Martin, Jennifer MB BAO BCH(Medicine); McAuliffe, Eilish BSc Psychology, MSc, MBA, PhD. A Systematic Review and Narrative Synthesis: Determinants of the Effectiveness and Sustainability of Measurement-Focused Quality Improvement Trainings. Journal of Continuing Education in the Health Professions: Summer 2021 - Volume 41 - Issue 3 - p 210-220 doi: 10.1097/CEH.0000000000000331
Research on After Action Review (2021)	Effect of after action review on safety culture and second victim experience and its implementation in an Irish hospital: A mixed methods study protocol McCarthy SE, Keane T, Walsh A, Mellon L, Williams DJ, Jenkins L, Hogan C, Stuart C, Rafter N. Effect of after action review on safety culture and second victim experience and its implementation in an Irish hospital: A mixed methods study protocol. PLoS One. 2021 Nov 18;16(11):e0259887. doi: 10.1371/journal.pone.0259887. PMID: 34793495; PMCID: PMC8601442.
Profile of QI initiatives in Ireland, to review the quality of their reporting and to assess outcomes and cost (2021)	Reporting Standards, Outcomes and Costs of QI Studies in Ireland: A scoping Review McCarthy SE, Jabakhanji SB, Martin J, *et al.* Reporting standards, outcomes and costs of quality improvement studies in Ireland: a scoping review. *BMJ Open Quality* 2021;**10:**e001319. doi: 10.1136/bmjoq-2020-001319