An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

Edition 2 July 2023

Quality and Patient Safety MATTERS

#AllThingsQuality

"Nothing about me without me"

Patient engagement celebration at Mayo University Hospital

How guidelines impact our lives and our death.

HSE National Clinical Guidelines for Post Mortem Examination Services updated

Just Culture:

CHANGING THE WAY WE THINK ABOUT PATIENT SAFETY

A publication from the HSE National Quality and Patient Safety Directorate

A message from the editorial team

Welcome! We are delighted to share with you our second edition of the Quality and Patient Safety Matters #AllThingsQuality newsletter with thanks to all our contributors. In this edition, you'll find the latest quality and patient safety news, stories from teams around the country, educational content and upcoming training, events and networking opportunities.

Our Patient Partner, Tiberius Pereira from Patients for Patients Safety Ireland (PFPSI) brings us an overview of the work of PFPSI. He also highlights steps you can take to tackle health literacy in your work and address the potential impact it has on patient safety.

You can read stories from the QPS Community on the Patient Safety Together Quality Day in Tipperary University Hospital, consultation with service users in Galway / Roscommon Mental Health Services, patient engagement in Mayo and the iSIMPATHY Medicines Review.

We share insights from NQPSD events Building a just culture in healthcare: a HSE Dialogue, National Quality and Patient Safety Symposium and SAFE collaborative. We also share the latest updates from Patient Safety Together which we hope is useful.

We welcome Professor Linda Mulligan, Chief State Pathologist to share her insight as Chair of the HSE Guidelines for Post Mortem Examination Services Review Group. She also shares the outputs of this work and the potential impact of these clinical guidelines on people's lives.

Finally you can catch up on the QPS TalkTime spring webinar series. We've listed all of this seasons topics ranging from psychological safety, safer surgeries, quality improvement in the community to adult safeguarding.

We hope that Quality and Patient Safety Matters will both inspire and guide you in your work. We welcome feedback about the newsletter or if you'd like to share a story in our next edition, find out how on page one. Our October edition will be focusing on the theme "Elevate the patient voice and safety through health literacy" as part of World Patient Safety Day.

For now, happy reading!

Juanita Guidera
Editor

Sheema Lughmani
Deputy Editor

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The newsletter is an interactive PDF. When you click on a hyperlink, it will bring you directly to the website, webinar, registration link, podcast or other resource mentioned (where links are available). To access, just hover and click on the text. This is the symbol you will see beside a hyperlink:

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If you would like to share your ideas for content in Quality and Patient Safety Matters, Edition 03, October 2023 please complete the online survey.

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Welcome to our second edition of the Quality and Patient Safety Matters #AllThingsQuality newsletter

There is significant change happening within our healthcare organisational structures at present. As we collectively seek to build the health services for future generations, we continue our work to provide the best possible care for people using services today. Our aim in this edition of Quality and Patient Safety Matters is for you to have an opportunity to hear about quality and patient safety developments from staff, patient partners and the National Quality and Patient Safety Directorate Team.

I want in particular to draw your attention to the NQPSD messages from Patient Safety Together. There is a Patient Safety Supplement on "Recognising and Supporting Adult Safeguarding". There is also a HSE National Patient Safety Alert which highlights the requirement for an immediate review of the HSE Paediatric Early Warning System (PEWS) Guidance (observation charts and training) to reflect the recent HSE Sepsis Programme guidance for children and young people (page 15). We hope that the information contained in these documents is both relevant and useful.

We want all people using health and social care services to consistently receive the safest care possible and the highest quality service. In order to do so, we know that our service delivery must be underpinned by a just culture. You can read more about our work in this area in our article on the recent HSE Dialogue: Building a just culture in healthcare (page 10).

As an organisation, a just culture means moving towards a values based supportive model of shared accountability. We are working together to build a psychologically safe environment where staff not only report incidents and near misses but have the skills and knowledge to identify and apply systems learning to improve safety. You can find out more about learning opportunities throughout our newsletter and in the NQPSD Prospectus of Education and Learning Programmes.

Thank you to all who contributed to this publication and thank you for taking the time to read it.

Best wishes,

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

What is the National Quality and Patient Safety Directorate?

The National Quality and Patient Safety Directorate is a team of individuals working across Ireland in partnership with HSE operations, patient partners and other internal and external partners to improve patient safety and the quality of care. 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 possible by:

- Building quality and patient safety capacity and capability in practice
- Using data to inform improvements
- Working with people to identify, understand and share safety learning, advocate for open disclosure and develop the national incident management system
- Providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Learn more about our work and our team www.hse.ie/nqpsd

Patients for Patient Safety Ireland - An introduction

In each edition of Quality and Patient Safety Matters, you will see articles from Patients for Patients Safety Ireland.

The patient is the only person experiencing the entire care process. Their voice matters.

What is Patients for Patients Safety Ireland?

Patients for Patient Safety Ireland (PFPSI) is an independent organisation. We aim to engage and empower patients and families, facilitating patient partnerships with health professionals and policy-makers to make healthcare services safer in Ireland. Uniquely, we follow a programme defined by the World Health Organisation which includes the Global Patient Safety Action Plan 2021-2030. PFPSI is the patient group specifically mentioned in the current HSE's Patient Safety Strategy.

For more than 10 years, PFPSI members have built a strong reputation advocating for safe, person-centred and quality healthcare with universal access and equity through collaborative patient engagement. If you are committed to patient engagement and wish that engagement to be constructive and effective, consider engaging with us.

How does PFPSI support Patient Partners?

Patient partners play an important role across healthcare in Ireland, so it is important that they have the knowledge, skills and confidence to engage effectively. PFPSI provides patient safety advocates with a clear framework for effective, collaborative engagement. All members receive training on the World Health Organisation (WHO) strategy and research for patient engagement, health literacy, the fundamentals of patient safety science and how to engage with health service agencies in Ireland. Regular meetings provide a forum to share learnings and best practice together with continuous improvement.

How does the World Health Organisation Patient Safety Programme seek to facilitate partnership?

The WHO Patients for Patient Safety Programme facilitates an equal partnership between empowered patients, health professionals, operators and administrators to:

- Bring the patient voice to every engagement, including events, meetings, committees and working groups.
- Create tools and initiatives to bring about meaningful engagement for health.
- Empower and engage patients, people, and health professionals through workshops and events.
- Bring stakeholders together through different initiatives to form partnerships, enabling understanding and information sharing, which in turn engages and empowers people and leads to safer, higher-quality healthcare.

What can you do?

Involve patient partners

As a healthcare worker, you can consider how you are collaborating with patient partners in the design and delivery of your service.

Become a patient partner

If you know people or you yourself are interested in becoming a patient partner, please feel free to share the PFPSI contact details or email us. We are delighted to welcome new members. Contact us for more information:
info@patientsforpatientsafety.ie.

Learn more

You can learn more about patient partnership by accessing the following webpages for more information:

Patients for Patients Safety Ireland
World Health Organisation

Get involved in World Patient Safety Day

The 17th September 2023 is World Patient Safety Day. Each year, services across the country and world celebrate the day in different ways. This year the theme is 'Engaging patients for patient safety' and our focus will be to "Elevate the patient voice and safety through health literacy".

If you would like to get involved, follow us on twitter via @patient_for and @NationalQPS to learn more over the coming weeks and to share your own ideas.

Date for your diary:
Sunday, 17th September 2023

World Patient Safety Day

"Elevate the patient voice and safety through health literacy"

This theme recognises the crucial role of health literacy to support patients, families and caregivers to take up their role in patient safety in healthcare fully.

Addressing the imbalance of power: health literacy

Tiberius Pereira, Patient Partner
Patient for Patient Safety Ireland

Almost half of the people you meet will have difficulty understanding information about their health. According to the European Health Literacy survey, completed in 2012, 40% of the Irish population have low levels of health literacy. This is linked directly to poor health outcomes.

This challenge is multiplied when you consider that when we are unwell, our capacity to concentrate can be affected. There is also an imbalance of power between healthcare professionals and patients. This can have a range of negative effects on patients' experience of care and willingness to say 'I don't understand'.

Empowering patients with knowledge, skills and confidence supports them to be active partners in their own care, with improved patient understanding and improved collaboration leading to fewer patient visits and better outcomes.

How do we tackle the imbalance of power and increase the level of health literacy?

There are a range of actions that can be taken by healthcare professionals and policy-makers in the short and medium term. PFPSI wishes to see an increased emphasis on Health Literacy. According to Centers for Disease Control and Prevention, there are two dimensions to Health Literacy: organisational and personal.

Organisational health literacy is the key area in which every healthcare professional can have an impact - seek to increase health literacy in every interaction with every patient. There are many excellent examples of this across healthcare in Ireland.

The path to improving health literacy is not always straightforward. One basic reason for this is that sick people are, by definition, not performing at their best. However, we wish to see personal health literacy initiatives for all members of the public, including in schools from a young age.

What is the difference between organisational and personal health literacy?

Organisational health literacy: how we equitably enable individuals to...	**Personal health literacy:** the degree to which individuals have the ability to...

find, understand, and use information and services to inform health-related decisions and, take actions for themselves and others.

The HSE has a number of existing initiatives and is committed to patient empowerment and engagement. The "Person and Family Engagement programme" Operational Performance and Integration focuses on engaging and involving patients in the design, planning and delivery of all care. This demonstrates a commitment to person-centred care, ensuring that care is appropriate to patients' needs and is respectful of their preferences.

The HSE's Integrated Care Programme also puts the patient experience at the centre of everything they do. It is based on the principles of illness prevention, patient empowerment, multi-disciplinary cross-service care planning and delivery, where all health and social care services work together to provide a flexible network of care responsive to the changing needs of patients and their families.

PFPSI is calling for patient engagement and empowerment - with the emphasis on empowering every patient.

What can you do to improve health literacy?

- **Raise awareness** of this challenge in your team.
- Check for understanding.
- Consider inviting one or several members of your team to **become Patient Empowerment Champions** to encourage individuals to ask questions and more.
- **Make health information more widely available** and in a manner that is easily understood. This is key to reducing health inequality. Consider informational videos which can be shown in every healthcare institution and in non-healthcare situations where people are in a waiting room.
- In the design and delivery of your service, **help people understand** the structure of the health service, how to access healthcare, how to navigate the system.
- **Encourage people to know their rights and responsibilities** of as set out in the National Healthcare Charter:
  * You and Your Health Service
  * "It's Safer to Ask" leaflet.
- **Signpost the HSE self-management supports for people living with long-term health conditions.** (Self-management support aims to increase a person's knowledge, confidence and skills when looking after their health. It is about helping people to learn more about their condition, set goals, problem solve and make plans to live a healthier life.)
- **Signpost peer support groups set up by advocacy groups.** (These can play an important role in patient empowerment for those with long-term conditions.)

Tipperary University Hospital hosts Patient Safety Together Quality Day

Maura Grogan, Quality Manager in conversation with Juanita Guidera, Editor

Like so many hospitals across the country, Tipperary University Hospital is at the heart of community. Everyone knows someone who works there, has worked there or is planning to work there. At any time, there is always someone from my family or friend circle attending as a day patient, an inpatient or the Emergency Department.

The hospital itself sits on a hill, always in our minds, consciously or unconsciously. I've sat myself as a patient on the side of the bed, in the quiet of the morning, eating the nicest tea and toast on the planet, looking out at the mountains that surround and thought you would not get the same view in a five star resort.

When you attend as a patient, when things go well, you leave so grateful for the care you received but you never really know what happens in the background to make it flow. You don't understand the complexities - the planning, business cases, training, upkeep, labour and most importantly the collective efforts of the people - each person the professional at what they do, interdependent and working together to create the environment so that as a patient, all I had to worry about was myself.

On the 17th May 2023, I had the pleasure of attending the hospital's Quality Day to witness the commitment of staff working throughout the hospital as they showcased their efforts to continually improve quality. It was eye opening - the effort, innovation, creativity, skill, knowledge and heart. The work is for their community, their family. In the following article, Maura Grogan, Quality Manager shares a little about that day, the work of the team and why it is so important to the hospital.

Could you tell us a little about this year's Quality Day?

Each year Tipperary University Hospital hosts a Quality Day to instigate and give visibility to the quality projects within the hospital which are supported by our General Manager, Maria Barry. The theme this year was "Patient Safety Together at Tipperary University Hospital".

We had 21 presentations and 33 posters involving over 50 staff from all departments and disciplines. Over 206 staff attended the day. We also had additional support from our Patient Representative Service Users Forum and our Inclusion Working Group. Usually we have one of our patients telling their story. This year we went further, Ms. Jo Lonergan, a Patient Service User Representative chaired the afternoon session.

What do you think makes this work so successful?

The Quality Day helps build and develop our learning culture and this reflects on improvement in practice, the patient experience and patient safety. What is great about it is that it shows the overall effort within the hospital and that brings ownership and satisfaction. Together we have built up a trust in each other and in our teams. This helps our staff to be proactive, willing and empowered to suggest a change.

The quality initiatives would not be sustainable if they were not embraced by our staff. Teamwork underpins the success of the initiatives to deliver the safe care we want for ourselves and our loved ones.

How was the day received?

Colleagues who completed the evaluation forms acknowledged how the presentations and posters informed them of what is happening in other departments and disciplines.

What did they say? "Proud to be working in TippUH" | "Can't believe the amount of work going on" | "exceeded my expectations" | "Very informative and valuable information."

There was also discussion about the previous days @QPSTalkTime webinar which I had the opportunity to co-host live from Tipperary University Hospital.

What topics did the QPS TalkTime focus on?

Four teams shared examples and key learnings from their quality improvement work including the:

- Pink safety magnet - to help staff quickly recognise a deteriorating patient
- Critical care skills - simulation training for the multidisciplinary team on a series of critical care scenarios
- Medication safety during a paediatric emergency, focusing on supporting staff to identify the correct dose of medication in complex cases which may also be time sensitive, and
- Elimination of hospital acquired Clostridioides difficile.

These projects and the Quality Day all demonstrate the impact of multidisciplinary teamwork on patient safety. They also demonstrate clearly how an emphasis on a learning culture has improved practice and patient experience. Three examples are on the next page...

Pictured below from left to right are:

- **Panelists for the QPSTalkTime Live from Tipperary University Hospital: Elaine Egan, Patient Safety Strategy Co-ordinator; Shannon Power, Clinical Skills Facilitator; Dr. Andri Engelbrecht, Consultant in Emergency Medicine; Sarah-Jane Weissenbach, Clinical Skills Facilitator; Maura Grogan, Quality Manager; Ailish Mansfield, Clinical Skills Facilitator; Audrey O'Reilly, Chief Pharmacist and Maria Barry, General Manager. Missing from the photo is Dr. Marcella Lanzinger, Consultant Anaesthesiologist, Clinical Director Critical Care Medicine; Heather Power, Clinical Skills Facilitator and Dr. Sumera Bashir, Paediatric Registrar.**
- **Staff and patient partners at the Patient Safety Together Quality Day.**
- **Denise Conway, Clinical Nurse Specialist sharing her presentation on the Community Intervention Team (CIT) and Outpatients Parenteral Antimicrobial Therapy.**

Heather Power, Clinical Skills Facilitator
Development and use of drug preparation sheets in Paediatrics

As a Senior Nurse in the Paediatric Unit, Heather observed the stress and anxiety experienced by staff when calculating complex weight based calculations. She designed single sheet drug preparation sheets for emergency drugs using the Children's Health Ireland critical care formulary. The sheets were passed by the Drugs and Therapeutic hospital committee and are available in all Paediatric areas. They provide information on the drug doses and how to make up the infusion. The information sheets were welcomed by the Paediatric team, providing them with confidence and knowledge to prepare and deliver drugs safely, effectively and efficiently to vulnerable children.

Aoife O'Brien, Inflammatory Bowel Disease (IBD) Clinical Nurse Specialist
Specialised support for patients with IBD

Aoife sees newly diagnosed inpatients referred by either the medical or surgical team for education about their diagnosis, medication and ongoing support for Crohns or Ulcerative Colitis. She speaks with approximately 18-20 patients per week in two clinics. Her IBD helpline is proving to be a great success with almost 620 calls logged in the last year. To prevent the need for patients to present to the emergency department with signs of prolonged severe inflammation, resulting in long-term damage to their physical and psychological health; issues can be discussed with the consultant or dealt with in the most appropriate way, an endoscopy referral sent, an outpatients appointment booked, a prescription signed and sent out to the nominated pharmacy. Patient safety is at the core of care for IBD warriors. This includes liaison with GPs, ongoing assessment of risk factors and prescribing and deprescribing as required.

Reports from patients are very positive since the development of this personal service which allows their issues to be dealt with in a timely manner. Patients appreciate dealing with the same nurse and the access they have to the gastroenterology team via the helpline. All of these combine to improve patient confidence that they are getting the best care possible.

Fiona Ryan, Senior Pharmacist
Impact of Pharmacist attendance at morning medical handover meeting

Medication reconciliation has been recognised as an important intervention in challenging medication errors which pose a serious risk to patient safety. Since January 2023, a pharmacist has attended morning medical handover meetings in Tipperary University Hospital. This has enabled the early identification of high-risk patients for medication reconciliation. At the meeting doctors and the pharmacist highlight patients that require a medication reconciliation. Criteria used by the pharmacist to identify patients include; high-risk conditions where a delay in the patient receiving their regular medications may have a significant impact on their condition (e.g. Parkinson's disease and epilepsy), patients with dementia and those admitted due to an adverse drug reaction. More than half of patients that receive a medication reconciliation require an intervention. The most common discrepancy being an omission of a pre-admission medication. This has improved patient care as patients that require a medication reconciliation are identified in a timely manner.

What type of projects did teams work on?

The projects varied significantly. A sample of the winning posters and presentations included:

Overall Presentation Winner
"Elimination of hospital acquired Clostridioides difficile in a HSE Model 3 Acute Hospital"
Audrey O'Reilly, Elaine Egan and Dr. Sumera Bashir, C Diff QI Team

People's Poster
"Paediatric venepuncture and cannulation - expanding practice"
Heather Power, Paediatric Clinical Skills Facilitator

Judge's Poster:
"Speech and Language Therapy Department patient information leaflets"
Chiara Healy, Yvonne Kerry and Elaine Miscandlon, Speech and Language Therapy Department

Best Local Initiative
"Pink magnet"
Shannon Power, Clinical Skills Facilitator, Medical and Surgical Wards

Recognition of Patient Safety Together
"We're all in this together"
PJ Ryan, Support Service. Our own "Keepers of the house"

Team Working for Patient Safety
"Training, A collaboration between Theatre and Maternity"
Kate Browne, Maggie Dowling, Dr. Mostafa Abdalla and Team

Service Development
"Addition of IBD CNS to the Gastroenterology Team for management and support of patients with IBD"
Aoife O' Brien, Clinical Nurse Specialist

Patient Centred
"Overview of the benefit of referral for comprehensive geriatric assessment for the older person admitted to an acute setting"
Eamonn Cooney and Dr. Arslan Sohail

What are your top tips for others trying to implement quality initiatives?

> **"If it's one thing that I have learned, it's only through working together that we can make improvements that sustain. Being open to learning and creating a psychologically safe space to learn and work in matter. Both of these will assist us to deliver safe care to the patients that it is our privilege to care for. Working together, we ensure their safety."**
>
> **Maura Grogan, Quality Manager**

Where can you learn more?

You can watch the @QPSTalkTime webinar live from Tipperary University Hospital. You can also watch webinars on psychological safety or creating a learning culture.

If you have queries you can contact:
Maura Grogan, Quality Manager: Maura.Grogan@hse.ie

Consultation with individuals who avail of our services and those who support them

In conversation with Clara Meehan, Health and Social Care Professional (HSCP) Lead and Cathal Kilcline, Service User Representative, Galway / Roscommon Mental Health Services, CHO2.

The Project Team in Roscommon Mental Health Services identified the need to develop a method for direct engagement with service users and family members / carers as part of best practice. Clara Meehan, Heath and Social Care Professional Lead and Cathal Kilcline, Service User Representative engaged with 162 individuals who avail of our services and family members. This work happened across four service areas in Galway / Roscommon Mental Health Service (Roscommon Acute Mental Health Unit, Community Mental Health Team, Training Centres and the Psychiatry of Later Life (POLL) Service).

How was co-production utilised in the approach?

The team used co-production in the design and implementation of this project by facilitating equal and active participation of service users, family members and service providers.

A co-produced questionnaire was used to gather feedback from service users and family members regarding their experience of the service and to identify areas for service improvement / development. The questionnaires requested feedback on services attended, information provision, access to therapeutic services and supports, waiting times, therapeutic relationships and family involvement / support.

A mixed data collection method was utilised in gathering the data. This involved using the questionnaire in a variety of ways, for example paper format, interview in person / via phone or WebEx or electronic version distributed via email. The data collected was collated for data analysis.

What needs were identified during the process?

Eight key themes were identified from the data and highlighted the need for:

- Greater family engagement and support.
- More therapies and supports including specialist interventions.
- Easier access to the Mental Health Services - especially in a crisis.
- A new acute inpatient unit with additional bed capacity.
- Development of an electronic service user passport.
- Embedding the qualities required by healthcare professionals working in Mental Health - for example, empathy, compassion, listening and knowledge.
- Sharing of service user feedback regarding their experience of the training centres.

A workplan has been developed to address the key findings of the service user / family member consultation and is aligned to Sharing the Vision (2020) and the Patient Safety Strategy 2019 - 2024.

Pictured at the Roscommon Project Team Day (October 2022) are from left to right
Back row: Cathal Kilcline (Service User Representative); Pat Dolan (Project Lead); Anthony Fitzpatrick (Regional Nurse Practice Development Co-ordinator); Charlie Meehan (Head of Mental Health Services); Gerry Farrell (Keynote speaker).
Front row: Laura Costello (A/Senior Executive Officer); Clara Meehan (HSCP Lead); Dr. Sabina Feeney (Clinical Director) and Helen Early (Area Director of Nursing Galway / Roscommon).

What has been achieved to date?

During Q1 and Q2 of 2023, the following has been achieved:

- Service user / family member feedback has formed the basis for the consultation process involved in the development of the Strategy for the Mental Health Services in CHO2.
- An audit of therapeutic services and supports has been completed which will identify the existing gaps in the service.
- An Enhancing Family Engagement Co-production Project Team is being established and aims to develop a suite of resources for service providers in CHO2 that strengthens family engagement across the service.
- The HSCP lead and Service User Representative are collaborating with Mayo Recovery College on incorporating “Values in Action” into the Recovery Principles Training.
- Recovery principles training has been provided by REGARI Recovery College to over 12 Consultants and NCHDs.
- Updated Directory of Services on the Westbewell platform and the development of the Wellbeing app “The Good Place” via the Communications group.

How has the process been received and will it continue?

The feedback from the engagement process has been extremely positive from both the perspective of the staff, service users and their family members / carers. Engagement is ongoing and will expand to other service areas throughout 2023.

Where can I find further information?

For further information on this project, please contact:
Clara Meehan, HSCP Lead, Roscommon Transition Team | 0876304633 | clara.meehan1@hse.ie.

Patient engagement celebration at Mayo University Hospital "Nothing about me without me"

In conversation with Ciara McLaughlin, Patient Engagement and Partnership Improvement Co-ordinator

Mayo University Hospital held an event to celebrate patient engagement in March 2023. Hospital Volunteers, Patient and Family Experience Advisors, Quality and Patient Safety and Pharmacy Teams came together to showcase some of the projects they have been involved in.

Patient and Family Experience Advisors:

- shared their experiences of their role with patients, doctors, nurses and other staff,
- looked for more suggestions for improvements and projects they could initiate or get involved with, and
- launched an updated Patient Information Booklet, a Purposeful Visiting leaflet and new leaflets for the Wellness Walkway which was opened by the advisors last October.

What is the Wellness Walkway?

The Wellness Walkway aims to promote the health and wellbeing of patients during their recovery from illness and injury. The walkway is 130m long with stunning photographs of local landscapes, exercise stations and seated areas to allow patients get away from the busy ward environment.

Caitriona Davey, Clinical Nurse Manager 3 and Wellness Walkway Project Team member said:

"We have designed the walkway to support patients to remain active during their hospital stay and we have exercise stations designed by physiotherapists at intervals along the walkway with wall panels illustrating different lower and upper body exercises."

How will the hospital continue to develop this work further?

Ciara McLaughlin, Patient Engagement and Partnership Improvement Co-ordinator shared that:

"My role works to facilitate patient engagement and partnership in the hospital to bring about meaningful initiatives and improvements. I lead on the recruitment and support to our Hospital Volunteer Team and Patient and Family Experience Council, in partnership with our excellent existing advisors and lead volunteer Brendan.

I will also be facilitating training sessions for staff, capture feedback from patients and identify themes from complaints to address any improvement opportunities or to recognise excellence."

Lorraine Cooney, the new Patient Advice and Liaison Co-ordinator spoke about her role:

"I appreciate that being in hospital can be a vulnerable time for patients and their families. I hope the role of PALS provides a contact point to offer support and advice.

I am passionate about making each patient encounter as positive as possible, by championing effective communication and ensuring the patient's voice is heard, either directly or through a nominated individual. I am also committed to ensuring patient feedback is channeled towards learning, as we strive to continually improve the patient experience in MUH."

The Patient Advice and Liaison Service provides a confidential, impartial liaison service for patients and their carers. PALS offers support and advice, responds to concerns and takes comments and suggestions for service improvements.

How are patients involved in Mayo University Hospital?

Patient and Family Engagement has been an integral part of Mayo University Hospital for several years.

There is an active council of Patient and Family Experience Advisors. They work alongside staff to bring the perspectives and lived experiences of patients and families directly into the planning, delivery and evaluation of care. They also sit on a number of key committees and project groups within the hospital and bring their experience and ideas to these areas.

Photos by John Mee. Pictured above from left to right are:

- Representatives of the Wellness Walkway Project Team: John McCormack and Caitriona Davey.
- Hospital volunteers: Brendan Coyne; Lucia Killeen; Kathleen Ruane; Breda Kilkenny; Mary O'Neill.
- Some members of the Patient and Family Experience Council and the Assistant Director of Nursing: Catherine Walsh, Principal Social Worker; Craig Allen, Assistant Director of Nursing; Ciara McLaughlin, Patient Engagement and Partnership Improvement Co-ordinator; John McCormack, Patient Experience Advisor; Fiona McGrath, Physiotherapy Manager; Terry McCole, Patient Experience Advisor; Caitriona Davey, Clinical Nurse Manager; Lorraine Cooney, Patient Advice and Liaison Coordinator.

Members of the Mayo University Hospital Volunteers Service also participated on the day to help people learn more about the role and to recruit more volunteers. Over 50 members of the community have participated in the scheme since March 2012. Volunteers seek to ensure patients and visitors have a warm, friendly welcome and are assisted with directions or information needed.

Catherine Donohoe, Hospital Manager said:

"I fully believe that meaningful patient engagement is one of the key requirements in safe quality care. This engagement means having patients involved in design, planning and delivery of care. Patients should feel this level of engagement at every point of contact and as hospital manager I am committed to support progressing this in MUH".

Where can I get more information?

This work is part of an overall hospital plan to achieve an ongoing culture of patient centred quality improvement and to enhance the experience of patients and their families.

For more information see www.saolta.ie/hospital/muh or contact Ciara.McLaughlin1@hse.ie.

Addressing a leading cause of avoidable harm through iSIMPATHY Medicines Review

In conversation with
Emma Jane Coyle, Leon O'Hagan, Ciara Kirke

Did you know that medication and its omission is a leading cause of avoidable harm across the world? In Ireland, over 250,000 adults receive 10 or more prescribed medicines on a regular basis. The concept of 'appropriate polypharmacy' recognises that patients can benefit from multiple medications provided that prescribing is evidence based, safe and reflects patients' clinical conditions and priorities.

What was the iSIMPATHY project?

iSIMPATHY stands for "implementing Stimulating Innovation in the Management of Polypharmacy and Adherence Through the Years". The project sought to introduce person-centred Medicines Reviews, focusing on patient needs and wants, as well as addressing clinical and safety considerations. It used a 7-step approach to facilitate shared decision-making and improved understanding, in addition to optimising medicines to improve outcomes.

iSIMPATHY was funded by the EU Interreg VA programme, involving a partnership between the HSE (National Quality and Patient Safety Directorate, CHO 1, CHO 8 and EU North South Unit), the Scottish Government and Medicines Optimisation Innovation Centre in Northern Ireland.

Within the HSE, the project recruited and trained five Senior Pharmacists to work in eleven GP practices in counties Donegal, Sligo, Leitrim, Cavan, Monaghan and Louth where they delivered comprehensive Medicines Reviews.

Why was iSIMPATHY so significant in Ireland?

Pioneering in its approach in Ireland, iSIMPATHY represented the first time, outside of a research setting, that pharmacists are working in GP practices, with access to patients and full patient records during a Medicines Review process.

7 STEPS TO APPROPRIATE POLYPHARMACY

How was iSIMPATHY incorporated into GP Practices?

Patients were identified through MDT referrals or clinical searches. In contrast to Northern Ireland and Scotland, currently there is no legislation in place for pharmacist prescribers in Ireland. Therefore, project outcomes were reliant on GP resources and availability to action changes to prescribed medications.

What were the outcomes of iSIMPATHY?

Comprehensive Medicines Reviews derived clinical and quality of life benefits, improvement in appropriateness of medication, as well as long-term direct and indirect economic benefits.

€208 Per Review saved

Over 2500 Patients reviewed

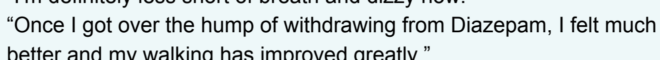
Average 6 Comorbidies per Patient

Pre-review Meds = 12.2
Post-review Meds = 11.0
(Optimising + Deprescribing)

Average 11 interventions per Patient

What did patients feel and say about this service?

Patient experience was captured through Patient Recorded Outcome Measures (PROMs). 88% of patients reported improvements in at least one domain for example, reduced adverse drug reactions and improvement in ability to engage in activities of daily living. Patient comments included:



"I'm definitely less short of breath and dizzy now."
"Once I got over the hump of withdrawing from Diazepam, I felt much better and my walking has improved greatly."
"Dad's mood and appetite are much better since his medication review."

What do GPs say about the service?

"iSIMPATHY is one of the most impactful changes in General Practice in 20 years."
"Yes, it is extra work but this is the nature of the beast when it comes to polypharmacy. It is time well spent. Time is possibly a reason why it has never been addressed before."
"I think having a clinical pharmacist associated with or attached to every practice in the country is going to absolutely essential."

What happens next?

iSIMPATHY has demonstrated the benefits of the introduction of a dedicated resource to deliver comprehensive person-centred medicines reviews, adding capacity and capability in primary care.

The project ended in March 2023; however, mainstreaming has been committed to in the National Service Plan 2023. Four iSIMPATHY pharmacists remain in post in CHO 1 and 8 until the end of 2023. The service is now known as OPT (Optimising Prescribing Together). We continue to provide comprehensive Medicines Review in partnership with patients and prescribers, utilising the 7-steps.

What is the impact of inappropriate polypharmacy?

The risk of inappropriate polypharmacy increases with the number of medications prescribed. It can have a substantial detrimental impact on patients and the healthcare system including:

- Avoidable harm
- Cumulative side effects
- Increased healthcare utilisation
- A higher rate of GP and Emergency Department visits
- Avoidable hospital admissions
- Medicines waste
- Adverse drug reactions are responsible for 1 in 10 hospitalisations; 71% of which are avoidable
- Therapeutic failure - intentional and non-intentional non-adherence
- Drug - drug interactions and drug - disease interaction.

Useful resources for Polypharmacy Medicines Review

- See www.isimpathy.eu/resources
- Complete the Polypharmacy and Medication Review eLearning Programme available via IIOP and HSeLanD.

For information on pharmacist-led, comprehensive, polypharmacy medicines reviews contact: ciara.kirke@hse.ie (HSE iSIMPATHY Project Lead) | OPT@hse.ie | emma.coyle2@hse.ie | leon.ohagan@hse.ie

The WHO third Global Patient Safety Challenge, Medication Without Harm, aims to reduce severe avoidable medication-related harm by 50%, globally in the next 5 years.

Could it be sepsis?

In conversation with Denise McCarthy, ADON Sepsis South/South West Hospital Group

With World Sepsis Day approaching on 13th September 2023 Katie O'Connor, CNM2 deteriorating patient University Hospital Kerry says "We all share a common goal - the best possible care and outcomes delivered to our patients".

We are urging everyone to be aware of Sepsis, be familiar with the signs and symptoms and be ready to ask … "Could it be Sepsis?"

Who is at risk of sepsis?

Anyone with an infection can develop sepsis, but some people are at higher risk:

- Adults 65 or older.
- People with weakened immune systems.
- People with chronic medical conditions, such as diabetes, lung / kidney disease, cancer, and pregnant women.

This year we are urging you to promote World Sepsis Day to raise awareness not only to peers but to your family and members of the public. Early recognition and treatment are key to survival.

How can you recognise sepsis?

The most commonly reported symptoms include:

- S Slurred speech and / or confusion
- E Extreme shivering, muscle pain, fever
- P Not passing urine
- S Shortness of breath and / or fast heart rate
- I If it feel like you are going to die
- S Skin that looks blotchy or a rash that doesn't fade when you roll a glass over it

In children, the signs to look out for include:

- Abnormally cold to the touch
- Skin looks mottled, bluish or pale
- Breathing very fast
- Unusually sleepy and difficult to wake
- A rash that doesn't not fade when you press it
- Having fits or convulsions

Also, in children under 5

- Not feeding
- Vomiting repeatedly
- Has not had a wet nappy in last 12 hours.

Share your work and learn more

The National Sepsis Team are holding a Sepsis Summit on the 19th September 2023 in Dublin Castle. We are seeking submissions for consideration for presentation at the Summit from all healthcare professionals including original research, quality improvement projects and case reports broadly focusing on sepsis.

Save the date:
Sepsis Summit
19th September 2023
Dublin Castle

QPS Leadership Network

On the 20th June 2023, a cohort of QPS staff from around the country took part in the second day of the HSE-UCD co-designed programme. The aim is to bring QPS leaders together in a forum where they can learn about enacting collective leadership to support quality and patient safety improvement, and collaborate and learn from each other to address challenges they encounter.

During our second day of in person sessions, featured topics included communicating and managing relationships with external stakeholders to promote QPS, learning from the experiences of QPS Leads in acute and community settings, partnering with patients to improve care, and playing a serious discussion-based game to support learning and create a safe space for conversations about implementing assisted decision making in practice. We had the pleasure of welcoming some excellent speakers and thank attendees for their fantastic engagement and input throughout the day

Pictured below from left to right and top to bottom:

- **Tiberius Pereira, Patients for Patient Safety Ireland; Dr. Aoife De Brún, Assistant Professor/Ad Astra Fellow, UCD; Kara Madden, National Patient Forum and Chair Patients for Patient Safety Ireland; Professor Eilish McAuliffe, UCD IRIS Centre, School of Nursing, Midwifery and Health Systems**
- **Dr. John Fitzsimons sharing his knowledge and wisdom with participants on the HSE QPS Leadership Network**
- **Dr. John Fitzsimons with Angela FitzGerald, CEO HIQA**
- **Dr. Mary Browne, Clinical Lead QPS Educate and John McElhinney, Group Quality and Patient Safety Manager, Saolta University Health Care Group**

Pictured below are members of the iSIMPATHY Project Team
Back row (left to right): Ciara Kirke (Project lead, NQPSD) and Leon O'Hagan (iSIMPATHY Pharmacist). Front row (left to right): Trevor Hunter (Primary Care Pharmacist CHO 1); Clare Kinahan (iSIMPATHY Pharmacist); Jacqueline Treacy (iSIMPATHY Pharmacist); Emma Jane Coyle (iSIMPATHY Pharmacist); Niamh Feeley (iSIMPATHY Pharmacist); Celine Croarkin (Project Manager, CHO 8) and Joanne O'Brien (Primary Care Pharmacist CHO 8). **See page 8.**

JUST CULTURE:

Changing the way we think about patient safety

Delegates completing the SLIDO at Building a just culture in healthcare: a HSE Dialogue

Just Culture is a values based supportive model of shared accountability which recognises that individual staff should not be held accountable for system failings. Instead, organisations carry a level of accountability for its safety culture and need to encourage staff to report incidents and near-misses and apply systems-learning to improve safety.

Why does a just culture matter in healthcare?

In healthcare we know things may go wrong and incidents can occur. However, we recognise a punitive system does not improve patient safety. Responses to patient safety incidents need to focus on the identification of systemic issues that contributed to the incident rather than on individual actions.

Creating a culture of transparency and psychological safety allows for and encourages reporting of patient safety incidents. Learning from these patient safety incidents improves patient safety.

The HSE is committed to creating an environment that encourages staff to speak up, including reporting incidents or raising issues that pose a risk to the safety of service users, without fear of reprisal. It is essential that our staff feel confident to report incidents so that there is learning from such events and the healthcare system is improved.

How is this being achieved?

The HSE has recently established a working group to support a consistent and evidence-based strategic approach to building a just culture and the application of fair, appropriate and shared accountability when patient safety incidents arise.

This working group includes membership from all levels of the HSE, clinical and patient representatives and academic experts in the field of just culture. It is supported by the Project Lead, Dr. Samantha Hughes, NPQSD QPS Incident Management Team.

The group is co-chaired by Lorraine Schwanberg, Assistant National Director for QPS Incident Management NQPSD and Dr. John Fitzsimons, Clinical Director NQPSD and Consultant Paediatrician, CHI Temple Street. It reports to Dr. Colm Henry, Chief Clinical Officer.

Building a just culture in healthcare: a HSE Dialogue

To facilitate organisation wide change and begin these conversations, the NQPSD QPS Incident Management team hosted the HSE's first just culture conference on 23rd May 2023 in Croke Park.

The conference set HSE staff and partners on a collective journey towards fostering a just culture.

"Creating an environment for staff to feel psychologically safe to speak up and to report and learn from incidents and near-misses is essential."

Leadership plays a crucial role in shaping and sustaining a just culture. Culture change takes time and requires the full and committed support of the whole organisation.

Opening the conference, Dr. Colm Henry, HSE Chief Clinical Officer, expressed how a just culture in healthcare provides safer patient care and ensures the fair treatment and psychological safety of staff.

HSE CEO, Bernard Gloster expressed the HSE's commitment to creating a compassionate, just, fair and open culture where staff are actively encouraged to speak up for safety, feel psychologically safe to speak up and to report and learn from incidents and near-misses.

CEO Bernard Gloster speaking at HSE conference "Building a Just Culture in Healthcare: a HSE Dialogue" (23rd May 2023, Croke Park).

Restorative Just Culture

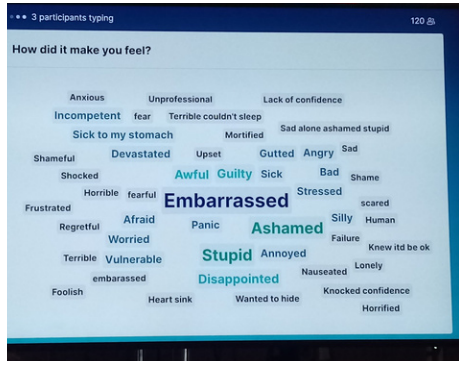
Keynote speakers Amanda Oates, Executive Director of Workforce and Joe Rafferty, Chief Executive, Mersey Care NHS Foundation Trust shared their experience, wisdom and advice from their journey through the implementation of a restorative just culture.

Messages from the keynote presentations highlighted the “what” rather than the “who”, asking us to look at the factors within the system that contributed to the incident rather than focusing on the actions of the individual.

Restorative practices ask who are impacted by the event, what are their needs and what can be done to resolve and repair those harms.

"We don't come to work thinking an incident will happen."

In the keynote address, Amanda Oates shared the emotional toll of being involved in an incident. She also asked the audience about their experiences and how they or their colleagues felt. Amongst the numerous emotions expressed by the audience, embarrassed, ashamed, devastated and vulnerable were some of the top responses.



The key message from all speakers on the day emphasised that a just culture is an organisational wide objective. It needs to be championed and supported by our leaders and co-implemented with our patient partners and stakeholders. Most importantly, it needs to be supported by good communication processes and education, and replace 'fault finding' and a ‘blame’ culture with ‘learning’ and ‘risk reduction’ in conjunction with a clear understanding of fair accountability.

Together, we can create an environment where staff feel psychologically safe to report incidents, where system failures are addressed proactively, and where continuous improvement thrives for the benefit of patient safety and quality of care.

Learn more:

The incident management team have a number of resources to expand your just culture knowledge:

- Just Culture Guide
- Just Culture Overview
- Just Culture Summary
- Just Culture Assessment Framework
- Presentations from the event Building a Just Culture in Healthcare: a HSE Dialogue

You can also view the @QPSTalkTime on Just Culture with Amanda Oates and Joe Rafferty.

Learnings from the National Quality and Patient Safety Symposium

The National Quality and Patient Safety Directorate (NQPSD) bi-annual symposiums provide a space for sharing and creating a unified approach to delivering the HSE Quality and Patient Safety agenda. These events are opportunities to strengthen working relationships, generate consensus and alignment on Quality and Patient Safety (QPS) developments.

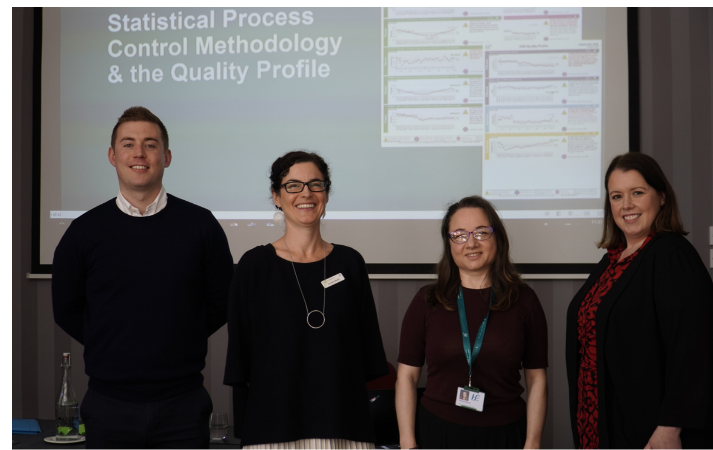
Our first symposium of 2023 was held on the 23rd April in Portlaoise. Below we share an overview of four workshops. 120 participants had the option to attend two of the four.

- Aligning Quality Improvement with Safety Improvement,
- QPS Data for Decision Making Toolkit,
- Patient Safety Together: Sharing Learning and Improving, and
- Human Factors.

Quality and Safety Improvement Workshop

Centering on the theme “Aligning Quality Improvement with Safety Improvement”, the QPS Improvement Team held an interactive QI Solution Design workshop session which focused on practical solutions to common areas for improvement. Energising and inspiring QI suggestions flowed, providing real value to participants on topics such as reducing harm from falls; enhancing meaningful engagement with patients; embedding good practice in clinical audit; collecting and analysing data relating to the deteriorating patient; and supporting local services to implement national clinical guidelines. Feedback was very positive, and participants left the room with a plethora of ideas and plans for bringing their quality and safety improvement ideas forward.

Dervla Hogan, Roisin Egenton and Maureen Flynn



Stephen Barrett, Jennifer Martin, Florina Rizoaica and Gemma Moore

Introduction to Quality and Safety Data for Decision Making Workshop

The QPS Intelligence team facilitated the ‘Introduction to Quality and Safety Data for Decision Making’ workshop. They discussed how including a quality agenda item at meetings can support a board, committee, management or leadership team to improve oversight and accountability of quality and patient safety. Workshop participants were introduced to two complementary quality agenda items:

1) a ‘Quality Profile’ where a selected critical few indicators across domains of quality are presented. Statistical Process Control (SPC) methodology is used to analyse and display variation over time and across a system, and to differentiate between expected and unexpected variation.

2) ‘People’s Experience of Quality’ where both positive and negative patient, service-user, family and staff experiences are shared at meetings.

Through a series of tasks participants gained an understanding of common versus special cause variation and how SPC can better demonstrate quality and safety performance over time. Participants watched a video of a patient sharing their experience and discussed the impact hearing a person’s experience would have at meetings.

Veronica Hanlon and attendees

Highlights from the Human Factors workshop

There was great interest in the two Human Factors workshops that were facilitated by Margaret Codd and Dr. Mary Browne. The workshops looked at what we mean by Human Factors and how incorporating this knowledge and thinking into everyday practice can help us to improve safety and wellbeing for both staff and patients.

Attendees participated in interactive exercises that demonstrated the breadth and depth (or potential scope) of human factors application in all areas of healthcare (both clinical and non-clinical services), and the importance of systems thinking in how we design our care systems and process for safer and better for all.

In their feedback, attendees could see the relevance of human factors in the work they do every day and were enthusiastic about how it aligns and fits with what they are already doing. In group conversation, they posed great questions that we think are well worth sharing:

- What's next, how can I find out more about human factors?

  For more information about the current HSE Human Factors programmes and resources visit the: QPS website or QPS 2023 Prospectus

- How can we integrate human factors knowledge and thinking into our practice in a systematic, integrated way?

  This is something the NQPSD is working on currently in collaboration with service leaders, Human Factors academics and experts. Through the QPS networks and website we will keep you informed of developments and resources as they become available so what this space!

If you have particular questions or expertise in the area of Human Factors that you would like to share with us, please contact Margaret.Codd@hse.ie.

Margaret Codd and Mary Browne: human factors workshop

Patient Safety Together community meets for the first time at NQPSD Symposium

The symposium also welcomed the first in person gathering of the recently formed Patient Safety Together community for staff working in quality and patient safety.

A workshop on Patient Safety Together allowed members and other delegates to come together and learn more about the continuing work of Patient Safety Together. Using the 'Liberating structure TRIZ' (Theory of Inventive Problem Solving) the workshop cleared space for innovation as we explored how we could improve sharing of learning within our own services.

Members also had the opportunity to attend other workshops and network with like-minded colleagues from across the health service. If you are interested in joining the Patient Safety Community please email patientsafetytogether@hse.ie.

Learn more:

The next NQPSD Symposium will be held in quarter four. Exact dates and location will be confirmed closer to date, with invites issuing from nqps@hse.ie.

Members of the National Quality and Patient Safety Directorate

Situation Awareness for Everyone: sustainability and spread

Claire Roe, Mary Doyle, Sinead O'Neill, Susan Jacob

Situation Awareness for Everyone (SAFE) is a short, six month collaborative patient safety education programme funded by the National Quality and Patient Safety Directorate (NQPSD) and facilitated by expert faculty of the Royal College of Physicians of Ireland (RCPI). The purpose is to improve interdisciplinary communication, build a safety culture, and enhance outcomes for patients in Irish hospitals. The programme has been delivered for the last four years, with the fifth cohort of participants commencing in autumn 2023.

Workshop to build Sustainability

On 14th May, the RCPI and NQPSD hosted the first ever SAFE "Sustainability and Spread" workshop in Dublin. The event brought together past participants of the programme as well as clinical teams and senior leader to share their experiences and ongoing commitment to SAFE in their hospitals. Patient partners also attended to share their lived experience of patient safety and the importance of communication and shared decision making with patients and their families.

The workshop recognised the important work that participants undertake in integrating patient safety methodologies into their daily practice. It offered attendees the opportunity to explore successes and challenges to date, along with a renewed focus on empowering teams to spread and share their learnings about patient safety in their hospitals and to scale up within hospital groups.

Dervla Hogan, Yvonne Young, Blathnaid Connolly, Maria Lordan Dunphy, Dr. Peter Lachman, Mary Bedding, Rachel MacDonell

What is SAFE?

The SAFE Collaborative brings together clinical teams from different hospital sites to seek improvement in any early warning system - in adult, maternity, neonatal, paediatric or emergency care settings. Participating teams represent experienced clinical decision makers and key care providers. Subject matter experts work together with improvement experts, using quality improvement methodologies to implement changes at the front line of healthcare.

This six day blended learning programme provides training in safety theory and practical experience in designing and running safety huddles to: reduce error and harm to acutely unwell patients, improve communication between healthcare professionals, improve the working culture for staff providing patient care; and increase the involvement of patients and families in their care.

A key feature of the SAFE programme is enabling participants to develop their own bespoke safety huddles, thereby creating an environment of psychological safety for participants. Maria Lordan Dunphy, Assistant National Director Quality and Patient Safety, says:

"The COVID pandemic highlighted the importance of effective communication processes and psychological safety for staff in order to improve patient safety. Psychological safety developed within a safety huddle enables healthcare professionals to feel comfortable seeking help and advice from one another, and from senior colleagues. The benefits to staff and patients, as well so to the overall quality and safety of our service, cannot be underestimated. Situation awareness is the foundation for good clinical decision making and helps healthcare workers improve patient outcomes."

How can I apply?

Applications are accepted annually in June. Applications are now closed for the 2023-2024 cohort, but are expected to open again next May 2024 for interested teams. Learn more on the RCPI website.

Dr. Peter Lachman leading a discussion during the workshop

> "Situation awareness is the foundation for good clinical decision-making and helps healthcare workers improve patient outcomes."

Adapting to a changing world: equity, sustainability and wellbeing for all

In conversation with Sheema Lughmani, Deputy Editor

This year's International Forum on Quality and Safety in Healthcare challenged the international improvement community to find innovative solutions to address health inequalities. The presentations, workshops and speakers urge us to reconsider what truly matters in delivering great care. The resounding message? It is simply about treating everyone with respect, making the most of our resources and taking a holistic approach to quality care.

What are health inequalities?

Health inequalities, rooted in various factors such as socioeconomic status, race, ethnicity and education, significantly impact patient safety outcomes. People with lower incomes often face barriers in accessing healthcare resulting in delays and may be at higher risk of harm. Racial and ethnic minorities can experience unequal treatment and limited access to quality care. Limited education and health literacy can also lead to mistakes and compromise patient safety. At this year's forum, the international community was challenged to meet these inequalities head on to ensure that everyone receives safe and effective care.

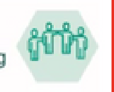
In Ireland, similar challenges exist within our healthcare system. In cases where minority populations face discrimination and unequal treatment can also impact patient safety outcomes. Disparities in accessing primary care, specialty services, and diagnostic tools can lead to delayed diagnoses, inadequate follow-up care and increased healthcare associated infections.

Ideas for improvement

What rang clear from every workshop and presentation was the international improvement community's commitment to actively taking steps to address these challenges. For example, ideas included policy reforms aimed at reducing financial barriers in accessing care in lower income communities. Access to diversity and anti-bias training in particular was highlighted as key to providing better education for all in understanding social determinants of health. Clear communication, plain language and accessible patient education materials were shown to enhance health literacy and patient engagement. Additionally, efforts were called to reduce geographic barriers to health services.

This year, the International Forum reminds us that we have the capability to find innovative solutions to build a healthcare system that embraces equity, ensures patient safety and meets the challenges of a changing world. Together we can create a healthcare system that is fair and inclusive for all. #OurHealthService.

New HSE National Patient Safety Alert, HSE Patient Safety Digest and Patient Safety Supplement now available



HSE National Patient Safety Alert: Update to the HSE Paediatric Early Warning System (PEWS) Guidance

PEWS observation charts and training material currently in use are in need of an urgent update to reflect the recent HSE Sepsis Programme guidance for children and young people. The current PEWS charts may not guide the clinical staff to a diagnosis of sepsis. A HSE PEWS governance group have reviewed the following documents and have made the following interim changes to align with new Sepsis Guidance for Children:

- Patient observation charts to include updated Sepsis Banner,
- PEWS guidance and training presentations, and
- Information for PEWS leads and trainers.

Who needs to take action?

This HSE National Patient Safety Alert (NPSA) is for action by all Hospital Group and Hospital CEOs, Directors / Leads of Quality, Patient Safety and Risk Managers, Heads of Service for Quality and Safety Service Improvement, General Managers, Clinical Directors, Directors of Nursing, Chairs Deteriorating Patients Committee / PEWS Committee. The e-alert system to each HSE hospital and community service. If not received please contact Patientsafetytogether@hse.ie.

New HSE Patient Safety Digest now available

The HSE Patient Safety Digest contains 19 journal articles and four reports relating to patient safety. They are sourced from high-quality, national and international peer reviewed periodicals. The information and learning shared in these publications is relevant to anyone with an interest in improving patient safety in our health services.

Patient Safety Supplement: Recognising and Supporting Adult Safeguarding

This Patient Safety Supplement focuses on adult safeguarding within older persons' services and services for persons with disability. Its purpose is to highlight the key role staff play in recognising and responding to abuse of vulnerable adults in order to put in place appropriate safeguarding measures.

Available on the Patient Safety Together website.

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

National Quality and Patient Safety (QPS) Competency Framework for Ireland

Why do we need a QPS competency framework for the Irish health system?

Training and education are key components in improving QPS and at present there is a wonderful opportunity to build a shared consensus around QPS related knowledge, skills, abilities, and behaviours required to deliver safe quality care within the Irish healthcare system.

A national QPS competency framework will support and inform national educational and training programmes and how we can best prepare staff for engagement in QPS work in practice.

What is the aim of the competency framework?

Its aim is to standardise the approach to building QPS competencies across the healthcare system and to provide a guide for evidence-based resources to support people to continually assess and develop their competence in QPS.

Who is working on this?

The HSE, in collaboration with colleagues at University College Dublin (UCD), is working on this two-year project to define what components should constitute the relevant competencies to support staff, students and patient partners in education, training and engagement in QPS activities.

This is a collaborative research project led by Dr. Mary Browne from the NQPSD and Dr. Aoife De Brún at the UCD Centre for Interdisciplinary Research, Education, and Innovation in Health Systems (UCD IRIS Centre), School of Nursing, Midwifery and Health Systems, UCD.

How are we developing this QPS framework?

Work has commenced to collaboratively develop an evidence-based QPS competency framework for staff, students, and patient partners to identify the competencies required to support them in delivering quality safe care. This research aims to co-design an evidence-based QPS competency framework by harnessing available knowledge internationally, learning from stakeholders in the Irish system and determining through co-design the structure and content to best prepare the health workforce to engage in QPS at all levels in the Irish healthcare system.

What are the benefits?

We believe there are many benefits of a QPS competency framework in building a collection of competencies that together define successful performance and development for an organisation. There is an opportunity to promote consistency and clarity around language, key skills and competencies for QPS. This will inform staff how to integrate QPS into their work, and will support job descriptions, employee induction, and professional development planning in relation to QPS. It will support academic bodies to guide and inform the development of under and post graduate curricula. It provides an opportunity to build shared ownership for this framework, at policy level, at service delivery level, at regulatory level, and across professional groups and academic bodies.

For further information:
If you would like to learn more please contact:
Email: Dimuthu.Rathnayake@ucd.ie / Stephanie.Horan@hse.ie

Patient partners and HSE staff learning together

In conversation with Margaret Codd, Quality Improvement Facilitator and participants

Earlier this spring a group of Patient Partners and HSE staff became the first group to undertake the Facilitator Education Programme offered by the National Quality and Patient Safety Directorate. This programme is developed by the National Clinical Leadership Centre and the Centres for Nursing and Midwifery Education. Below participants share their experience of the two days 'in-person' sessions and the benefits of the practice session between the first and second day.

What was your motivation for doing the programme?

For me, it was about becoming better at getting people to talk and have conversations with others. Part of our approach in Patients for Patient Safety Ireland (PFPSI) is to run workshops and we needed to have this structure and approach to do that, so for us the timing was excellent.

Why did you decide to co-facilitate the practice session together?

We've worked together before but not like this. It was an opportunity to really collaborate as patient partners and staff together.

How did the practice session(s) go?

Overall it was very successful, we got great feedback. The programme facilitated me to use a creative approach and be inclusive so that every voice on the day was valued.

It also gave us a framework for design and the tools, cards, visual aids, and "7P's" to use as well as the chance to put what we were learning into practice. There was a kind of protection in knowing that we are still learning.

What were some of the challenges and learning from your experience?

- The time it took to prepare the session and the documents we used.
- Not knowing the physical layout of the room and so what to expect when I got there.
- Having dual roles on the day – as presenter and facilitator – understanding the difference now and being able to switch hats.
- Keeping the size of the group manageable and the content from being too heavy.
- Permission that it is OK to be human – as facilitators we're not the experts.

Would you recommend the programme?

Participants shared a unanimous yes that they would recommend the programme. They also commented on the usefulness of the framework and that the programme had provided them with "security and a springboard for further innovation and creativity".

Where can I learn more?

Anyone can become a great facilitator - if they have the right tool techniques and skills. This programme is about building and/or refreshing those skills. Information about the National Facilitator Education Programme is available in our Prospectus.

Participants on day one of the Facilitator Education Programme

The National Centre for Clinical Audit: NCCA Team reflections on our first year

As the National Centre for Clinical Audit recently celebrated one year since its launch, we reflect on progress to date and preview what to expect in the year ahead.

Did you know that the HSE National Centre for Clinical Audit (NCCA) was established within the National Quality and Patient Safety Directorate (NQPSD) in April 2022, following publication of the HSE National Review of Clinical Audit Report 2019?

Training and resources to support services to date

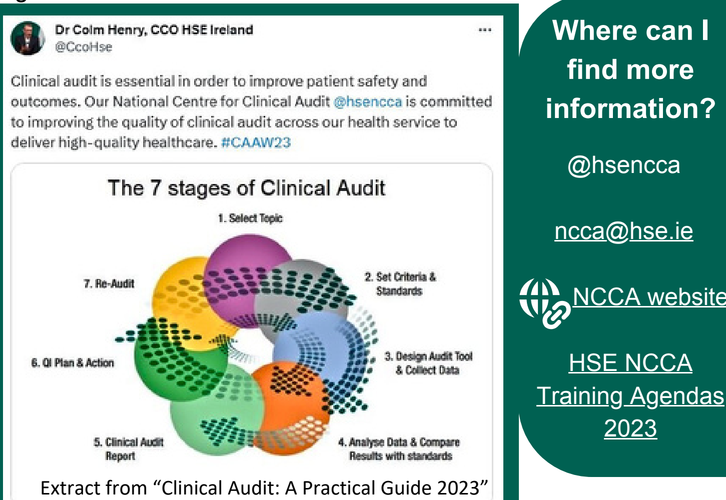
One of the key achievements over the past 12 months was establishing and implementing a Clinical Audit Education and Training Programme accessible to all HSE and HSE funded staff, in partnership with the Clinical Audit Support Centre, UK.

Over 700 staff participated in one of the 12 accredited training days between May and December 2022. All of the training courses are CPD accredited with RCPI and NMBI.

The NCCA also recently published "Clinical Audit: A Practical Guide 2023". The aim of this document is to assist and support healthcare staff to understand the stages of the clinical audit cycle, to help support best practice in clinical audit and to improve awareness of it as an essential and integral component of clinical practice.

How will we continue this commitment?

We will continue to work with stakeholders at national and local level to implement best practice and to provide governance and oversight for clinical audit nationally. All activities will aim to strengthen the development of clinical audit to ensure patient safety and promote improved patient outcomes. Expect exciting training opportunities, updated and new resources and lots of staff engagement.



Extract from "Clinical Audit: A Practical Guide 2023"

Where can I find more information?

@hsencca

ncca@hse.ie

NCCA website

HSE NCCA Training Agendas 2023

How guidelines impact our lives and our death

HSE National Clinical Guidelines for Post Mortem Examination Services updated

Professor Linda Mulligan, Chief State Pathologist and Chair of the HSE Guidelines for Post Mortem Examination Services: Review Group in conversation with Juanita Guidera, Editor

"It's half past eight, the children are in bed and you finally sit down after the day when there's a knock at the door. It's unexpected, he was out for a run. A neighbour found him."

"She had been in and out of hospital for the last few months, it was a cancer. You were with her at the end and held her hand. You have so many questions."

Last year in Ireland, over 7,000 post mortem examinations (PMEs) were performed. Whether the death was expected or unexpected, it can be difficult for families as they navigate both the grieving process and the formalities of this time. Whether a post mortem examination is required or requested, this medical procedure seeks to provide insight and answers about an illness or cause of death. How we have conversations about the PME process, how we support families with appropriate information to make decisions and how we demonstrate that we will treat people with dignity and respect matter.

In the following article, we speak with Professor Linda Mulligan, Chief State Pathologist and Chair of the HSE Guidelines for Post Mortem Examination Services: Review Group about their work to update the HSE Standards and Recommended Practices for Post Mortem Examination Services 2012.

Why did you get involved in this work?

I was honoured to be nominated by the Faculty of Pathology, RCPI, as both a trained histopathologist and forensic pathologist, to chair the review group that produced the new HSE National Clinical Guidelines for Post Mortem Examination Services. It was a huge opportunity to update the Standards and Recommended Practices for PME Services 2012 in order to provide a set of standardised and evidence-based guidelines.

What are the HSE National Clinical Guidelines for Post Mortem Examination Services?

These guidelines outline the recommended practices required in PME Services, based on current legal requirements, professional standards and international best practice.

Who are these guidelines for?

These guidelines are ultimately for the people using the Post Mortem Examination Services (PME) in the HSE and HSE-funded facilities. They will be especially helpful for mortuary, clinical and bereavement support staff during the PME process. In addition to the guidelines, the review group also developed a suite of template forms and booklets to support the process.

Why are these guidelines important?

A significant amount of learning has emerged in recent years through audits, investigations and through the recent COVID-19 pandemic about how we can improve PME services. Bereaved families are more aware of how the PME process can serve to answer questions they may have around the death of a person, especially where there are pathological conditions that may have implications for other family members. There has also been key learning about what needs to happen to ensure that the post mortem examination service is compassionate and centred on the needs of families and individuals using the service while also being reflective of international recommended practice.

Of greatest importance is the role that healthcare professionals have in the empathetic and effective establishment of recommended practices and guidelines. How we communicate, the information we share and our engagement with families has a significant impact, not only at the time of the PME but with a lasting effect on each person and family's experience of loss and bereavement. This work also shapes people's experience of and trust in the health service.

> **"These guidelines highlight that the PME service is there to support a clear focus on communication and empowerment of families. The PME service not only ensures that the final medical procedure the deceased person undergoes is carried out with dignity and professionalism, but also that the family are kept informed of every step and are involved in the necessary decisions around the PME. The guidelines recognise that the PME service is there to support, inform and hopefully provide closure and comfort to grieving loved ones and families."**
>
> **Professor Linda Mulligan**

Overview of the work members of the HSE Guidelines for Post Mortem Examination Services: Review Group

- Five meetings 9th June 2022 - 12th January 2023
- 26 members including four patient partners and an observer from HIQA
- Seven drafts based on feedback from the Review Group and both a targeted and open consultation process
- Development of revised clinical guidelines, a process map, a toolkit of 10 templates, 5 booklets and rapid literature review endorsed by the Faculty of Pathology, Royal College of Physicians Ireland.
- Two independent, external experts Professor Mike Osborn, President of the Royal College of Pathologists, UK and Dr. Margaret Bolster, Assistant State Pathologist reviewed the guidelines.

The Review Group was supported by the National Quality and Patient Safety Directorate.

What are the key changes?

New developments and updated information incorporated in the revised guidelines include:

- outlining the different requirements of coronial and hospital (consented) PMEs. [95% of PMEs in Ireland are coronial PMEs.
- the consent process for PME and for clinical research, which should be supplemented by the HSE National Consent Policy (2022) and the HSE National Policy for Consent in Health and Social Care Research (2022).
- a new process map, toolkit of template forms and patient information booklets to assist healthcare professionals in establishing and / or improving a standardised, high-quality and sensitive service for bereaved families in HSE and HSE-funded facilities throughout the country.
- formalising a designated person / role for tracking, overseeing and monitoring of organs in all PMEs in each mortuary and a designated family liaison / role (example from the multi disciplinary team, bereavement support etc.).
- formalising a process in the absence of family instructions regarding the managements of organs to respect the dignity of the individual.
- updates also include recommended practice regarding: perinatal care, minimally invasive PME, community deaths, principles of care for Garda identification, organ donation, guidance in the event of a lost / misplaced organ, inclusion of information electronically, responsibilities for communication and others.
- signposting resources and inclusion of a summary sheet for consideration when establishing local standard operating procedures.

How did the work happen?

In developing the HSE National Clinical Guidelines for Post Mortem Examination Services (2023) we were extremely fortunate to have strong foundations on which to build it: The HSE Standards and Recommended Practices for Post Mortem Examination Services 2012. A review group consisting of 26 individuals, including patient representatives, coroners and healthcare professionals from diverse backgrounds and specialties, undertook to update and add to the 2012 standards. Over six months, with both targeted and open consultations incorporating healthcare, cultural and religious groups, patient partners and organisations involved in various healthcare programmes, an updated set of national clinical guidelines evolved. The guidelines were informed by a literature review which was endorsed by the Faculty of Pathology, Royal College of Physicians Ireland. Two external experts Dr. Margaret Bolster, Assistant State Pathologist and Professor Mike Osborn, President of the Royal College of Pathologists, UK reviewed the guidelines.

The guidelines and associated documentation were also reviewed and accepted by the HSE Executive Management Team for Implementation in February 2023 and by the Patient Safety Quality Committee of the HSE Board in March 2023.

What are the next steps?

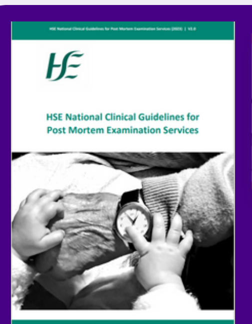
Dr. Ciaran Browne, General Manager, Acute Hospitals has been appointed as the implementation lead. The implementation will form part of a broader Mortuary Improvement Programme and over the coming period, Ciaran will be establishing a consultation process with services to determine the most effective implementation approach based on service need.

To commence this process, on Monday, 13th June 2023, staff were invited to participate in an online information session setting out the context, key changes and why this work is important. I was delighted to join this webinar hosted by Dr. Ciaran Browne and fellow panelists Mairie Cregan, Patient Partner and Patients for Patients Safety Ireland; Myra Cullinane, Senior Coroner; Sabrina Mullahy, Senior Pathology Technician and Juanita Guidera, NQPSD Review Lead. This webinar is available to watch online.

These guidelines are comprehensive, with an easy to follow table of contents. We hope they will provide a framework to assist healthcare staff as they support and guide families during a PME. It is our aim that these guidelines will inform a clear, open and comprehensive communication and consent process that is considerate of the emotional impact on bereaved families. I would like to express sincere thanks to all who provided input and expertise throughout the process.

Pictured from left to right:

- **Dr. Colm Henry, Chief Clinical Officer (CCO) and Professor Linda Mulligan, Chief State Pathologist and Chair HSE Guidelines for Post Mortem Examination Services: Review Group.**
- **Dr. Ciaran Browne, General Manager, Implementation Lead; Professor Mary Keogan, Dean of the Faculty of Pathology; Dr. Colm Henry, CCO; Dr. Orla Healy, Clinical Director, NQPSD; Professor Linda Mulligan, Chief State Pathologist and Chair HSE Guidelines for PME Services: Review Group and Juanita Guidera, NQPSD Review Lead.**



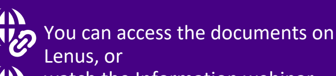
Suite of available documents

- HSE National Clinical Guidelines for Post Mortem Examination Services
- HSE National Toolkit of Templates for Post Mortem Examination Services
- HSE National Process Map for Post Mortem Examination Services

Template booklets

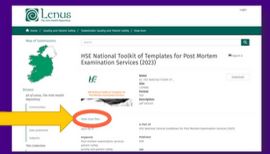
- Template adult booklet: A guide to a hospital post mortem examination (Consented or non-coronial PMEs)
- Template adult booklet: A guide to a coroner's post mortem examination
- Template perinatal booklet: A guide to a hospital post mortem examination (Hospital / consented / non coronial PMEs)
- Template perinatal booklet: A guide to a coroner's post mortem examination
- Template paediatric booklet: A guide to a post mortem examination (hospital and coroner's PME)

Where can I find more information?



You can access the documents on Lenus, or

watch the Information webinar via the NQPSD YouTube channel.



Catch up on the spring 2023 QPS TalkTime series

We know that service demands like a critically ill patient, short staffing or an unscheduled surgery or the 'lunchtime jobs' like picking up something for dinner, hanging out that load of washing, or flying to the shop to collect something, mean that you may not always be available for the QPS TalkTime lunchtime webinar. As we prepare for our autumn / winter series, we invite you to catch-up on episodes you may have missed from our spring series.

Since January, our lineup of speakers offered unique insights and shared their experience and knowledge on quality and patient safety recommended practices and current thinking. The overarching themes from this series of QPSTalkTime were how psychological safety and storytelling both underpin and influence patient safety. You can hear about quality improvement in acute and community settings, how to cultivating a learning health system, narrative based medicine, storytelling for QI or Safeguarding Older Persons amongst others.

So whether you're interested in developing your knowledge for personal or professional reasons, our spring series covers learning material for anyone interested in quality and patient safety. Catch-up and join the conversation at a time that suits you. The full repository is available via our website.

> **"I think the thing that has struck me is that all of the QI initiatives are simple solutions which can be implemented to increase patient safety - it doesn't have to be complex."**

> **"Thank you, I enjoyed the session - puts 'QI' back on my radar."**

> **"There were a lot of helpful links shared throughout the presentation."**

QPS TalkTime
2023 spring series

No. 1: How do we provide safe care in today's context? with Dr. Suzette Woodward

No. 2: Building a Learning Health System with Tom Foley

No. 3: Expand your QPS Knowledge | Explore the Prospectus of QPS Education and Learning Programmes 2023 with various guests

No. 4: How do you work in a system while improving it? with Dr. John Brennan and guests

QPS TalkTime Live from the International Collaborative Workshop on 'Implementation of the HSE's Patient Safety Strategy 2019-2024' with Dr. Orla Healy, Clinical Director, NQPSD; Rachel Kenna, Chief Nursing Officer, Department of Health; Professor Jeffrey Braithwaite, ISQua President; Dr. Ezequiel Garcia Elorrio, ISQua President Elect

No. 5: Narrative Based Medicine in your Practice with Dr. Muiris Houston

No. 6: Safer Surgeries...Steps to reduce risk of harm with Dr. Joan Power, Anne Jones and Aileen O'Brien

No. 7: Patient Partnership with Mila Whelan, Nicola Williams, Patrick James Power and Brid Ryan

No. 8: Patient Safety Together at Tipperary University Hospital with various guests

No. 10: The power of storytelling in Quality and Patient Safety with Loretta Jenkins, Dr. Gemma Moore, Ger Kilkelly and Jacqui Browne

No. 11: Safeguarding Older Persons with Tim Hanly, Bernie McNally, Geraldine Jolley

No. 12: Psychologically safe leadership with Anna Burhouse

To learn more, each episode listed is linked to the recoding or follow us on twitter @QPSTalkTime

HIQA launches online course on The Fundamentals of Advocacy in health and social care

In conversation with Rachel Flynn, Director of Health Information and Standards, Health Information and Quality Authority

Can you tell us about HIQA's online courses?

HIQA has developed a number of online courses to help staff working in health and social care services to implement national standards. All are available on HSeLanD, and they generally take no longer than an hour to complete. We have online courses on advocacy, rights-based care; adult safeguarding; and infection prevention and control (IPC) in community services. The feedback on the courses has been very positive and it has been an effective means of reaching a large number of people and improving knowledge and awareness around specific issues.

We recently launched a new course on "The Fundamentals of Advocacy in health and social care". It aims to support staff to incorporate advocacy into their day-to-day work.

What is advocacy?

Advocacy supports person-centred care by placing the person at the centre of any decision-making about their lives and their care.

An advocate is a person who protects and promotes people's human rights, while also respecting their autonomy, privacy, dignity, values, preferences and diversity. Staff in health and social care settings have an important role to play in promoting advocacy services and helping people to understand and access different types of advocacy.

All national standards published by HIQA have a focus on advocacy, particularly the National Standards for Adult Safeguarding and the Guidance on a Human Rights-Based Approach in Health and Social Care. The new online course will help health and social care staff implement national standards and support the rights of people using services.

Why is this important now?

We developed the advocacy course in response to a recommendation of the COVID-19 Nursing Homes Expert Panel Report. The report highlighted the need for advocacy services for nursing home residents, their families and friends during the pandemic.

Our stakeholder consultation identified a need to improve knowledge and understanding of advocacy in health and social care services. The first National Nursing Home Experience Survey, published in 2022, found that there was limited awareness of advocacy organisations and how to access advocacy supports among nursing home residents and their relatives and friends.

> 77% of nursing home residents said they did not know how to access advocacy services or organisations that could help them to express their views and wishes, and to help them to assert their rights.
>
> National Nursing Home Experience Survey (2022)

This was the lowest-scoring question in the survey. We have developed our new course and other resources - a booklet and an educational video on advocacy - to help staff in all health and social care services to support service users to access advocacy when they need it.

Tell us more about the new advocacy course

The new course will help staff understand their role in advocacy, which includes listening to people and supporting them to have their voices heard, to have their will and preference met, and to respect their autonomy and confidentiality. The course takes an hour to complete, and includes scenarios that help you think through advocacy issues in real life situations.

We also included interviews with an advocacy expert, a nursing home resident, a patient representative and nursing home staff. There are self-reflection questions throughout to help staff think about how they might incorporate advocacy into their work.

Over 6,000 people have completed the course on HSeLanD to date. The feedback on the course has been very positive. One person, working in residential care for older people, said:

"Going forward [I will] be more confident in helping and empowering people"

and one person working in a day service programme for adults said

"I really have a much better awareness of the various types of advocacy and supports".

Who was involved in developing the course?

Like all of our online courses, this new resource was developed with input from a wide range of stakeholders, including focus groups with service users and staff, advocacy groups and people with disabilities.

Where can I find more information?

Our online courses are available on HSELanD, where certificates are available on completion.

To learn more about advocacy in national standards, or access the booklet or videos see the HIQA website www.hiqa.ie.

Upcoming events

Upcoming training, events and networking quality and patient safety opportunities
All resources are hyperlinked (where available)

World Patient Safety Day

This year's World Patient Safety Day 2023 theme is "Engaging Patients for Patient Safety", in recognition of the increasingly crucial role patients, families and caregivers play in the safety of healthcare. The day aims to increase public awareness and engagement and enhance global understanding. Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes.

The National Quality and Patient Safety Directorate is collaborating with patient partners and staff across the HSE and will be having a number of engagement activities during the week of 17th September 2023. Follow @NationalQPS to stay up-to-date.

Date for the diary: 17th September 2023

Sepsis Summit

The National Sepsis Team are holding a Sepsis Summit in Dublin Castle. They are seeking submissions for consideration for presentation at the summit from all healthcare professionals. (See our article on Sepsis for more information.)

Date for the diary: 19th September 2023

Open Disclosure week

Open Disclosure week focuses on a number of themes connected to Open Disclosure including the patient perspective, documentation, approaches to implementation of the HSE Policy, training and staff support.

Dates for the diary: 2nd - 8th October 2023

National Quality and Patient Safety Symposium

The next NQPSD Symposium will be held in quarter four. Exact dates and location will be confirmed closer to date, with invites issuing from nqps@hse.ie.

Q-Community Annual Event

Q's annual event will feature a mix of live sessions, including keynote speeches, panel conversations and interactive workshops. This online event is for Q members. Join on Q Community's website.

Dates for your diary: 16th - 17th October 2023

Thank you for reading our second edition of Quality and Patient Safety Matters #AllThingsQuality. Please
- **share your ideas for the next edition via a short survey and / or**
- **tell us what you think or what you would like to read about by emailing juanita.guidera@hse.ie.**

We look forward to hearing from you.

Spotlight on upcoming training

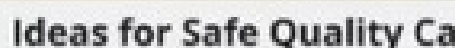
National Centre for Clinical Audit Training

Advanced Clinical Audit Course

11 | 12 | 21 September
04 | 05 October

Open Disclosure webinars

12 July
13 September



Walk and Talk Improvement - Latest Episodes

You can listen to our All-Ireland podcast. The aim is to improve patient care by capturing and learning from the personal stories about patient safety and quality improvement of people who work in and use health services.

Latest episodes:

Episode 5 - Human Factors: Designing for People

Episode 6 - Leaders on Leadership: Travelling their path in quality and safety

The series is available on Spotify, Amazon Music Prime, YouTube and Google Podcasts.

For additional quality and patient safety programmes and training, see our 2023 Prospectus!