An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

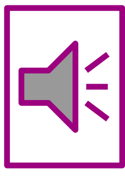
National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

28 June, 2022

Coming Soon…
Patient Safety: learning sharing and improving together

How we are running today's session

- You will be muted but the chat is open throughout - please post any questions or comments there and we will address them after the presentation.



- If your tech fails, don't worry – we're recording it so you can watch video and access the slides at your convenience. Audio is available via your PC or dial in:
  Telephone no: Irish: 01-5260058 / UK: +44-20-7660-8149
  Event number: 2734 025 7777#

- Please feel free to continue the discussion on Twitter: @Cath_E_Hogan @CcoHse @SHSIRL @patient_for @johnfitzsimons9 @QPSTalktime @NationalQPS @HSCQI

- Please help us to improve our QPS Talktime Webinars by completing a short feedback form (pop up window before you log out)

- You will receive an email from QPS Talktime confirming your attendance

To get started … we invite you to

Share using the chat box

- Your name, work and where you are joining us from …
- Invitation to respond to this question:

"Some of the good ways I share learning for patient safety are …"

Speakers today

Dr Colm Henry, Chief Clinical Officer is responsible for aligning clinical expertise and leadership across the healthcare system. His office is also responsible for setting quality and patient safety standards across the health system and ensuring these are met.

Lorraine Schwanberg, Assistant National Director for QPS Incident Management, NQPSD. Lorraine has worked in quality, incident management, risk and patient safety for many years.

Catherine Hogan, QPS Incident Management Team, NQPSD is the project lead where she has been focussing on sharing critical and improvement focused patient safety learning via a national Forum.

Flavien Plouzennec, User Researcher with the HSE Digital Team. Flavien's role involves research and testing to inform the design of digital content and tools.

Dr Marie Ward, Health Systems Research and Learning Facilitator, Quality and Safety Improvement Directorate, St James's Hospital.

Tiberius Pereira is a co-founder and former Chair of Patients for Patient Safety Ireland (PFPSI), the Irish presence of a worldwide WHO programme that engages and empowers patients and families and facilitates their partnership with health professionals and policy-makers to make health care services safer worldwide to enable the patient voice to be heard fully.

Facilitating the conversation

Dr John Fitzsimons, Clinical Director, HSE National Quality and Patient Safety Directorate and Consultant Paediatrician, Children's Health Ireland at Temple Street.

Dr Colm Henry
Chief Clinical Officer HSE

Patient Safety: learning, sharing and improving together

Tuesday the 28th of June 2022

What is it?

A freely available online resource that will enable all healthcare staff to access and download new and up to date patient safety information.

Facilitating, shared learning and Improvements

Its Purpose

To support staff in

- Identification and application of relevant learning for QPS improvements at all levels
- Shared learning facilitates closing the loop on incident reviews and reporting

To support patients and service users in

- Accessing QPS information that is up to date relevant information to the Irish healthcare system

Shared learning aims to prevent similar incidents recurring whilst making improvements to patient safety.

Build a culture that encourages staff to ***report patient safety issues and incidents*** and recognise the important role they play in preventing any potential future harm

New National Patient Safety Alert Working Group

- A key aspect of this project includes a mechanism for cascading National Patient Safety Alerts

- A Working Group is being established to support the ongoing identification, development and dissemination of PSAs

- Multidisciplinary and multi-agency membership

Delighted to announce today that Dr Darren McLaughlin, Consultant in ED Medicine, CUH & MUH Cork has been appointed as its Chair.

Project Collaborators

Sponsor: Dr Orla Healy – NCD, NQPSD
Steering Group Chair: Lorraine Schwanberg

- Patient Representatives
  - Patients for Patient Safety Ireland
  - HSE National Patient/Service User Forum
- HSE Digital
- Forum for Post Graduate Training Bodies
- National Patient Safety Office, DoH
- State Claims Agency
- CCO Clinical Forum

- Health Information and Quality Authority
- Mental Health Commission
- HSE Colleagues
  - Office of Nursing and Midwifery Services
  - QPS Acutes & Community
  - National Health & Social Care Professions Office
  - National Ambulance Service
  - National Screening Service

Míle Buíochas…

- Everyone who gave their time and effort to develop this important resource, through scoping exercise or through their engagement and commitment to the project steering group or project workstreams
- Dr Orla Healy and current Steering Group Chair, Lorraine Schwanberg
- Previous Sponsors and Chairs, Patrick Lynch and Cornelia Stuart
- Patient Representatives and specifically Tibbs Pereira, *Patients for Patient Safety Ireland*, who is joining us on the panel today

Background to the Project

Aim of today's webinar

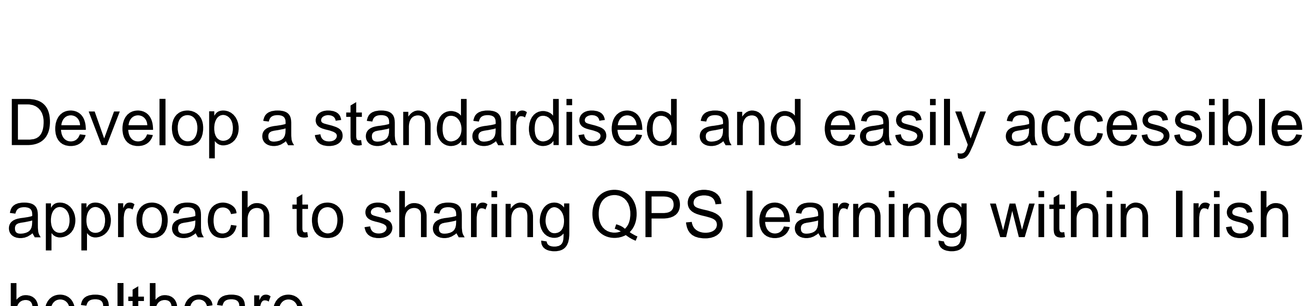
1. To introduce the new online resource

   Patient Safety: learning, sharing and improving together

2. To identify potential end users to assist in system testing over Summer 2022

Why?

Build on the work routinely undertaken by services and identify new opportunities to inform patient safety learning.



Develop a standardised and easily accessible approach to sharing QPS learning within Irish healthcare

Help support and close the loop on incident reporting by sharing learning to help prevent recurrence of incidents.

Key Ambition – Learning

National Standards for the Conduct of Reviews of Patient Safety Incidents (HIQA/MHC 2017)

- Standard 20 – structures in place to actively share learning

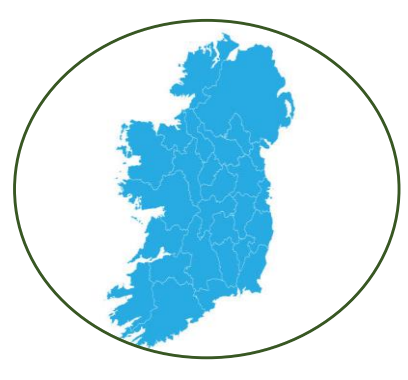
Incident Management Framework 2020

- Where feasible, that learning from incidents is considered alongside other sources of quality and safety information to inform improvement strategies

Patient Safety Strategy 2019 – 2024

- Key Ambition – Organisational Learning

Scoping



Literature

National Learning Systems

International Learning Systems

Partners

Within HSE

Partners

External to HSE

Project Aim

Develop a multi-modal approach to sharing learning – two way system

Learning direct from Patients/Service Users & Staff

- Pt & Staff Stories / QPS Safety Community

Learning from Incidents, Research & Data

- Pt Safety Alerts / Safety Supplements / Signposting to QPS academic papers, resources, conferences etc.

Resources will be shared within the new NQPSD website via a dedicated open access webpage

Patient Safety: learning, sharing and improving together

Patient Safety Alerts

A **Patient Safety Alert (PSA)** is a high priority communication in relation to patient safety issues, which requires HSE services and HSE funded agencies to take specific action(s) within an identified timeframe, in order to reduce the risk of occurrence or recurrence of patient safety incidents that have the potential to cause harm.

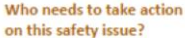
PSAs are issued by the HSE in conjunction with relevant stakeholders (subject matter experts, patient representatives, clinical & academic experts)

Patient Safety Alert

Date of Issue: January 15th, 2022
Unique ID: PSA 0001/2020

PRIORITY 1 – Immediate Action

Risk of Thermal Burn during New-born Screening



Who needs to take action on this safety issue?	This Patient Safety Alert (PSA) is for action by all Health Service personnel involved in undertaking new-born blood screening tests.
What is the safety issue?	Risk of thermal burn from actively heating an infant's foot prior to undertaking newborn blood screening test.
What action is required?	The pre-warming of an infant's foot with an external agent, prior to the heel prick sampling, **should be discontinued.** • Circulate this Patient Safety Alert to all staff involved in this process. • All training, protocols, policies, and documentation are to be updated to highlight this requirement.
When does the action need to be completed by?	All actions should be completed by **January 31st, 2022.**

Why is this action required?

The new-born blood spot test (heel prick) is an important, time-sensitive, screening investigation for metabolic and endocrine disorders in children. It is performed on all infants in the State between 72 and 120 hours of age.[1] It is undertaken mostly by Public Health Nurses in the infant's home or less frequently by Maternity or Children's Services, or Independent Midwives.

The use of warm water or any other external warming device should not be used prior to undertaking the new-born blood screening spot test.

The infant's heel is to be cleaned with a swab soaked in sterile water for injection.

This Patient Safety Alert has been issued by the following organisations: National Women & Infants Health Programme

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References

1. https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/information-for-professionals/a-practical-guide-to-newborn-bloodspot-screening-in-ireland.pdf

2. QPS Acute Operations NIMS data Reference HSE AO 22/09/2020

3. Hassan Z, Shah M. Scald injury from the Guthrie test: should the heel be warmed. Arch Dis Child Fetal Neonatal Ed 2005;90:F533-534

4. Ray R, Goodwin Y, Shepard A. Convection burn from use of a hair dryer for heel warming prior to the heel prick test- a case report. BMC Paediatrics 2011;30:11

5. Barker DP, Willetts B, Coppenijk VC, Rutter N. Capillary blood sampling: should the heel be warmed. Arch Dis Child Fetal Neonatal Ed 1996;74:F139-40

For more information about Patient Safety Alerts, see www.hse.ie/...

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Dissemination of Patient Safety Alerts

Patient Safety: learning, sharing and improving together

Open Access -

Repository of searchable PSAs

QPS E-Alert System -

PSAs forwarded to 'Designated Persons' in services

Patient Safety Supplement

An Stiúrthóireacht um Ardchaighdeán agus Sábháilteacht Othar
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PATIENT SAFETY SUPPLEMENT

Failure to Recognise Sepsis in the Deteriorating Patient

This *Safety Supplement* shares learning from reviews of cases reported from Irish healthcare settings to the National Incident Management System (NIMS) involving failure to recognise sepsis in the deteriorating patient. It includes a summary of evidence and patient safety strategies for healthcare providers to consider.

DRAFT - MAY NOT BE ACCURATE - FOR TESTING PURPOSES ONLY

CASE EXAMPLE

Ms. E was brought in by ambulance to the Emergency Department (ED) with fast atrial fibrillation and chest pain. Ms. E had a history of a fractured right humerus, Asthma, COPD, NIDDM, Atrial Fibrillation, Hypertension, CCF, and recurrent falls. The patient was seen by the ED Senior House Officer (SHO), and a provisional diagnosis of Angina was made.

Ms. E was admitted but her clinical condition deteriorated over the weekend on days 3 and 4. On day 5 she became unresponsive and hypoxic and subsequently suffered a cardiac and respiratory arrest. Despite intubation and ventilation and treatment in the Intensive Care Unit, Ms. E sadly died. Cause of death was multi-organ failure secondary to septicaemia. On review of the case it was identified that overall escalation protocols were not adhered to consistently by Nursing and Medical Staff

PATIENT STORY (As told by the patient) +/- picture

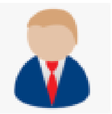
I had been unwell with vomiting and diarrhoea and had spent a number of days at home in bed. I had bad pains in her legs and on day 3 I fell, due to the severity of the pains. I felt very unwell throughout the day and later that night my husband called an ambulance and was brought to the ED ……………………………………………………………………………………………………

EXPERT COMMENT

EXAMPLE: Sepsis is a common time-dependent medical emergency. It can affect a person of any age, from any social background and can strike irrespective of underlying good health or concurrent medical conditions.

Internationally, approaches to sepsis management care based on early recognition of sepsis with resuscitation and timely referral to critical care have reported reductions in mortality from severe sepsis/septic shock in the order of 20-30%……….

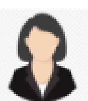
National Clinical Lead Sepsis:



Dr A. Smith, Consultant Anaesthetist

OR

Programme Manager, National Deteriorating Patient Improvement Programme & Sepsis:

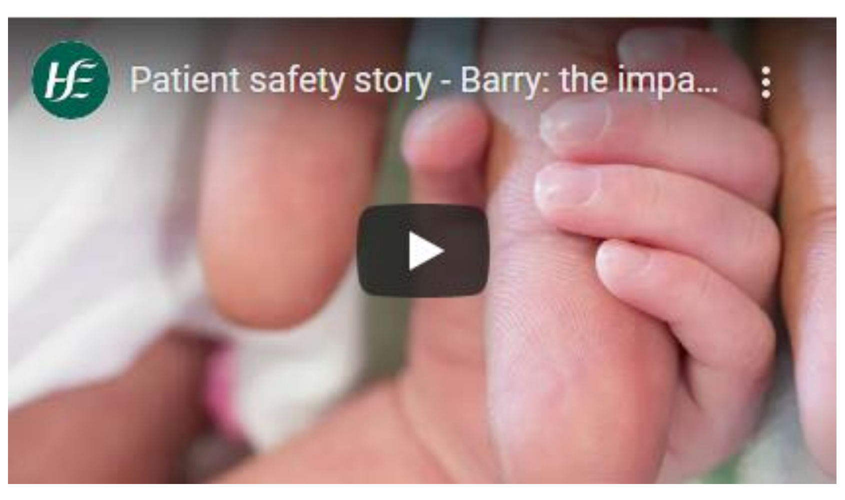


Ms. B. Murphy, Programme Lead

A **Patient Safety Supplement** (PSS) informs HSE and HSE funded agencies of timely and relevant quality and patient safety information for learning purposes.

Content will be identified from several patient safety intelligence sources including the analysis of incident reporting, reports from front line services, or new national or international research and evidence.

Safety Stories



The aim of Safety Stories is to give a voice to the patients/service users and staff who have been involved in, or impacted by patient safety incidents.

Storytelling has been shown to be effective in creating a dialogue to both increase safety awareness and assist in connecting knowledge to action.

Experiences can both be positive or negative and will be worthy of sharing in the interest of learning.

Patient Safety: learning, sharing and improving community

Exploring with a QPS working group how a Special Interest Group (SIG) can support QPS Staff through the Q Community's Platform

How?

- Peer Support
- Sharing of Resources
- Discussion Forum
- Sharing of Learning

Further Learning

Signposting to other patient safety content will also be included

New QPS Research

QPS Surveillance Data

QPS Resources

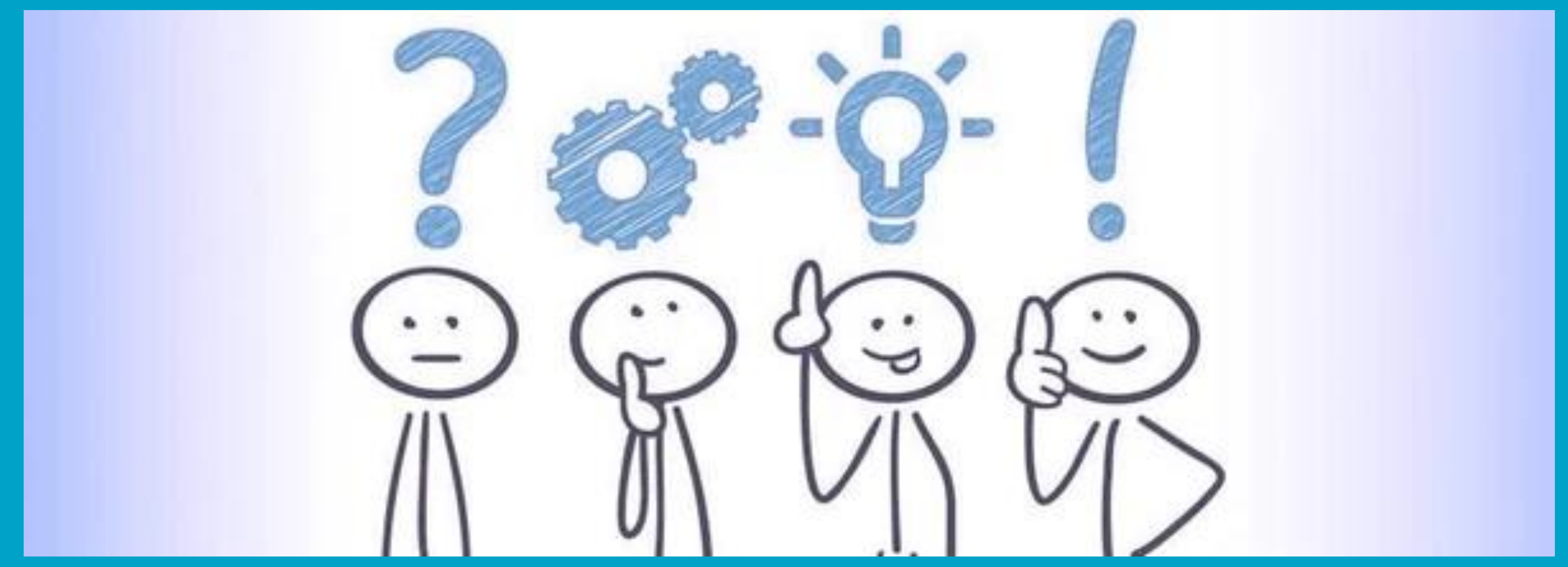
Links and Resources

- National Standards for the Conduct of Reviews of Patient Safety Incidents (HIQA/MHC 2017): https://www.hiqa.ie/reports-and-publications/standard/national-standards-conduct-reviews-patient-safety-incidents-0#:~:text=The%20Health%20Information%20and%20Quality,centred%20reviews%20of%20such%20incidents

- Incident Management Framework 2020: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-incident-management-framework-and-guidance-2020.pdf

- Patient Safety Strategy 2019 – 2024: https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf

- Link to undertake the HSE Digital survey: https://surveys.hse.ie/s/QPSwebsite/



HEARING YOUR THOUGHTS AND COMMENTS

Patients for Patient Safety Ireland (PFPS)

Patients for Patient Safety (PFPS) is a World Health Organisation (WHO) initiative aimed at improving patient safety through advocacy, collaboration and partnership.

Patients for Patient Safety Ireland is always seeking new members. More info on info@patientsforpatientsafety.ie or https://patientsforpatientsafety.ie/

Applications open | Apply by 24 June 2022 (extended)

Announcement!

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ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Postgraduate Certificate in Quality Improvement Leadership in Healthcare

- One year RCPI programme fully funded for HSE employees by the HSE National Quality & Patient Safety Directorate (NQPSD)
- Blended learning programme commencing September 2022

APPLY ONLINE

Apply at www.rcpi.ie
Submit by 24 June 2022!

HOW TO APPLY

- Form your multidisciplinary team of three people!
- Generate project idea focused on addressing common causes of harm outlined in the Patient Safety Strategy 2019-2024. *(Applications are particularly welcome from teams seeking to make patient safety improvements in the areas of mental health and medications safety).*
- Discuss with your senior manager and seek executive endorsement.
- Start your application online! *(You can save your progress but remember to submit by 5pm, Friday, 24th June!)*

A team- and project-based learning programme

Use this link o read more about the programme and how to apply :

https://courses.rcpi.ie/product?catalog=Postgraduate-Certificate-in-Quality-Improvement-Leadership-in-Healthcare

Handbook of Patient Safety:
A pragmatic, simple approach to Safety

Edited by Peter Lachman, Jane Runnacles, Anita Jayadev, John Brennan, and John Fitzsimons

- Explains patient safety theory in simple terms to help clinicians practice safely
- Provides day-to-day practical approaches to improve care
- Provides summaries with key take home points
- Written by clinical specialists with international expertise in patient safety issues
- Content applies patient safety theory to clinical practice with real world examples
- Reflects the WHO Patient Safety Curriculum

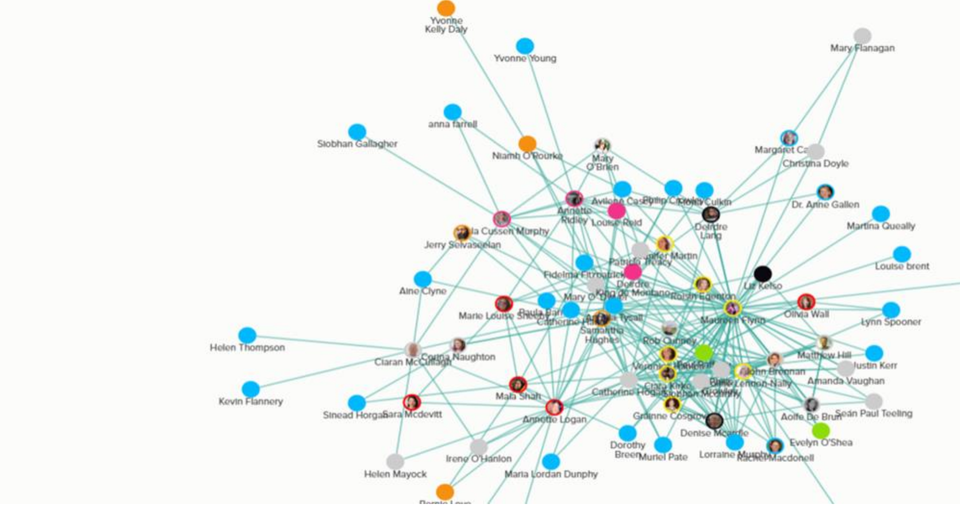
To purchase: https://global.oup.com/academic/product/oxford-professional-practice-handbook-of-patient-safety-9780192846877?cc=ie&lang=en

The QPS Ireland Network Map

To help visualise connections between people interested in quality, safety and improvement across Ireland: https://www.hse.ie/eng/about/who/nqpsd/qps-connect/network-map/

- How to join the map?
  - Visit the HSE website (see link in the chat)
  - Get sent your unique link to the map
  - Enter information about you, your professional characteristics and your interests
  - Log your connections

- How to use the map?
  - Filter the map by role, organisation, interests
  - View individual profiles
  - Connect and collaborate with others



Apply to become a member of Q Community

- All you need to know about applying can be found on the Q website
- You will be invited to complete an online application using the Q online portal
- If you have queries or require support, please contact our colleague via email

Caroline.Lennonnally@hse.ie

Upcoming Webinars: Dates for your diary ….

We are taking a short break for the Summer. We will be back in September with an exciting new Autumn/Winter Series

Thank you for your continuous support

Follow us on Twitter @QPSTalktime

Missed a webinar – Don't worry you can watch recorded webinars on HSE QPS Talktime page:
https://www.hse.ie/eng/about/who/nqpsd/qps-connect/qps-talktime/qps-talktime.html

Let us know how we did today ….

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS Talktime Webinars by sharing your feedback

We really appreciate your time, thank you

Contact: Noemi.Palacios@hse.ie to be included on our mailing list to receive QPS Talktime invitations