



An Stiúrtóireacht um Ardchaighdeán  
agus Sábháilteacht Othar  
Oifig an Phríomhoifigigh Cliniciúil

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

## QPS TalkTime

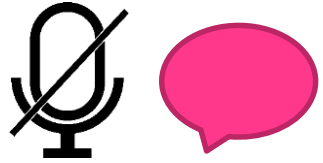


A community of quality and patient safety improvers

18<sup>th</sup> April, 2022

# Safer Surgeries...steps to reduce risk of harm

# 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 back on the NQPSD YouTube channel 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: 2733 032 9086#



- Please feel free to continue the discussion on Twitter: [@QPSTALKTIME](#)  
[@mapflynn](#) | [@Dervlahogan](#) | [@annejon24065844](#) | [@Aileen\\_OBrien1](#) | [@surgeryIreland](#)  
[@NationalQPS](#) | [#QIreland](#) | [#patientsafety](#)



- 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 ...
- Finish this statement:

***How do you play your part in Safer Surgery...***

# Speakers today



**Anne Jones**

Nurse Lead for Quality and Patient Safety Improvement, Ireland East Hospital Group



**Dr. Joan Power**

Consultant Haematologist



**Aileen O'Brien**

Assistant Director of Nursing, National Clinical Programme for Anaesthesia

## In conversation with



**Dr. Maureen Flynn**, Director of Nursing, QPS Connect Lead with the National Quality and Patient Safety Directorate

**Dr. Dervla Hogan**, Programme Manager (Operations), QPS Improvement, HSE National Quality and Patient Safety Directorate

## Joined in conversation with

**Ciara Hughes**

Programme Manager, National Clinical Programme in Surgery

**Miriam Kennedy**

Guideline Development group project Manager

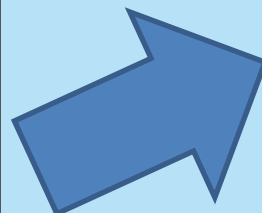
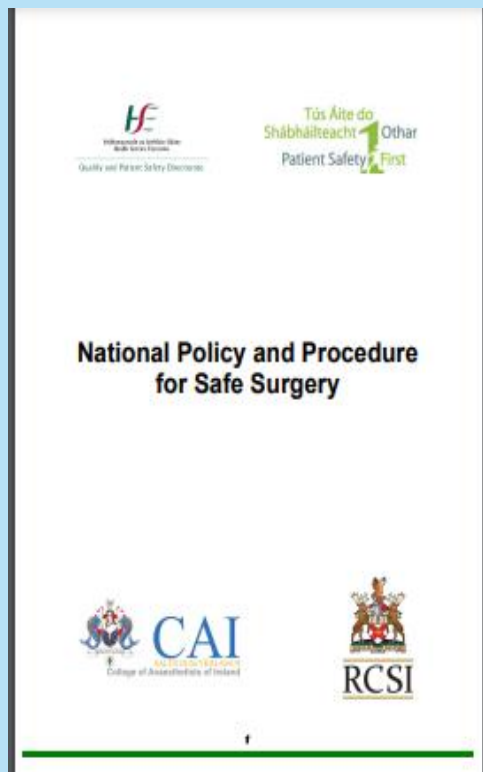
*Ms Aileen O'Brien*



*Nurse Lead*

*National Clinical Programme for  
Anaesthesia*







## WHO Guidelines for Safe Surgery 2009

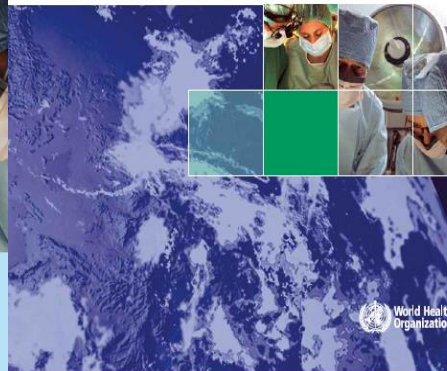
Safe Surgery Saves Lives



WORLD ALLIANCE FOR PATIENT SAFETY

## SAFE SURGERY SAVES LIVES

SECOND GLOBAL PATIENT SAFETY CHALLENGE



World Health Organization



## Patient Safety Strategy 2019-2024



Seirbhís Sláinte  
Níos Fearr  
& Forbairt

Building  
Better H  
Service

HSIB  
Healthcare Safety Investigation Branch  
www.hsib.org.uk

## National Learning Report Never Events: analysis of HSIB's national investigations

Independent report by the  
Healthcare Safety Investigation Branch (2020/006)

January 2021

# What is New?

## Two New Stages

- Briefing
- Debriefing

## Minimum Safety Checks

Human Factors –Teamwork, Communication

## Variations



## HSE Land E Learning Module

- Due for Launch - April 26<sup>th</sup> 2023
- Takes approximately 45 minutes
- Doesn't have to be completed in one sitting
- Knowledge checks as you progress with 5 minute assessment at the end
- Will have CPD points
- Transferrable between hospitals
- Key messages – Respect the Process and Play Your Part



# Clinical Audit

- Bi Annual audit
- Audit tool- structures and processes
- Retrospective & Concurrent Observational  
70/30%
- Sample size 20-50 cases
- Analysis, Reporting & Implementation of QI
- 100% Compliance

*Ms. Aileen O'Brien*



*National Clinical Programme for Anaesthesia*

*aobrien@coa.ie*

*Thank You*





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## QPS TalkTime



A community of quality and patient safety improvers

18<sup>th</sup> April, 2022

# Safer Surgeries...steps to reduce risk of harm

Abstract geometric lines in black on a white background, forming various overlapping polygons and triangles, primarily located on the left side of the slide.

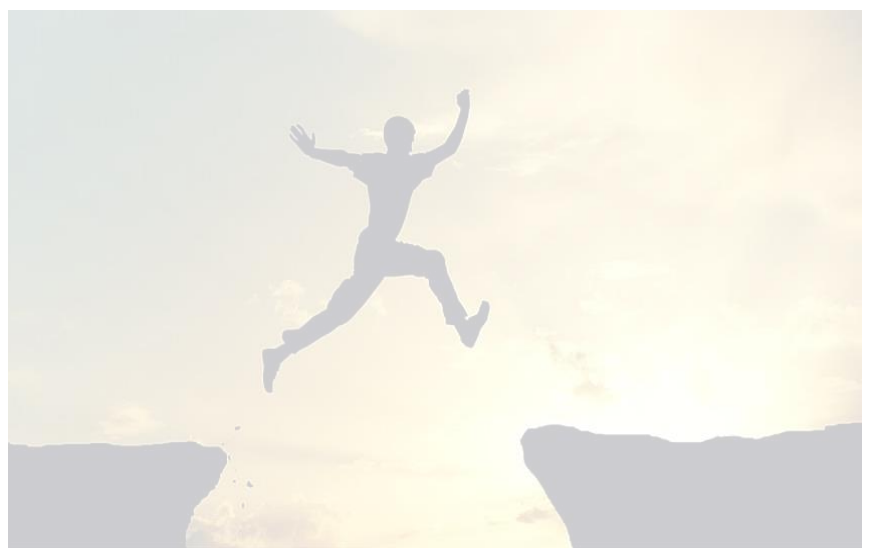
# IMPLEMENTING EVIDENCE INTO PRACTICE

**Anne Jones**

Nurse Lead for Quality and Patient Safety Improvement

Ireland East Hospital Group

April 2023



HOW DO WE GET THERE





It is widely reported in the literature  
that evidence-based practices  
(EBPs) take an average of 17 years  
to be incorporated into routine  
general practice in health care

*and*

Only about half of EBPs ever reach  
widespread clinical usage [1]

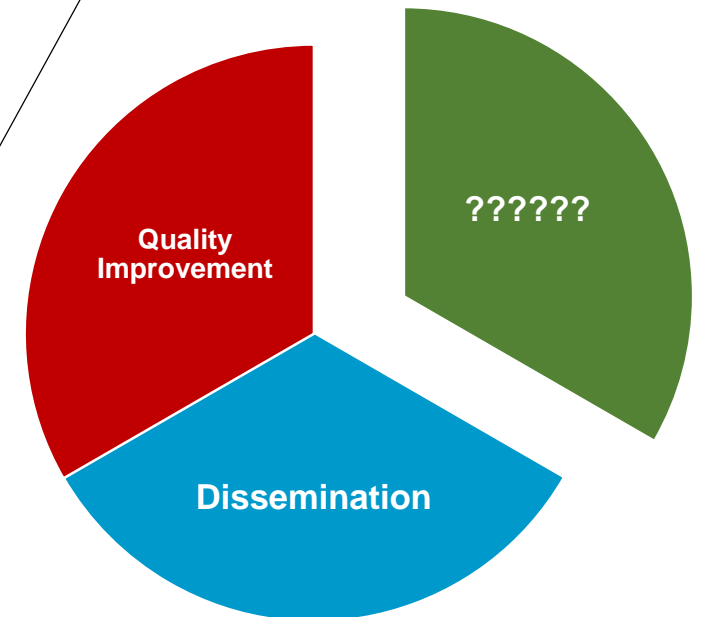
# ACHIEVING THE GOAL OF IMPROVING THE QUALITY OF HEALTHCARE.

**Dissemination**, refers to the spread of information about an intervention; verbal+/- electronic communication, provision of hard copies, launch events, often assisted by educational efforts

**Quality Improvement** Frequently when we identify a specific problem in a specific healthcare system, we employ QI methods to design and trial strategies to improve the specific problem for that specific healthcare system, e.g. system or process redesign

*But*

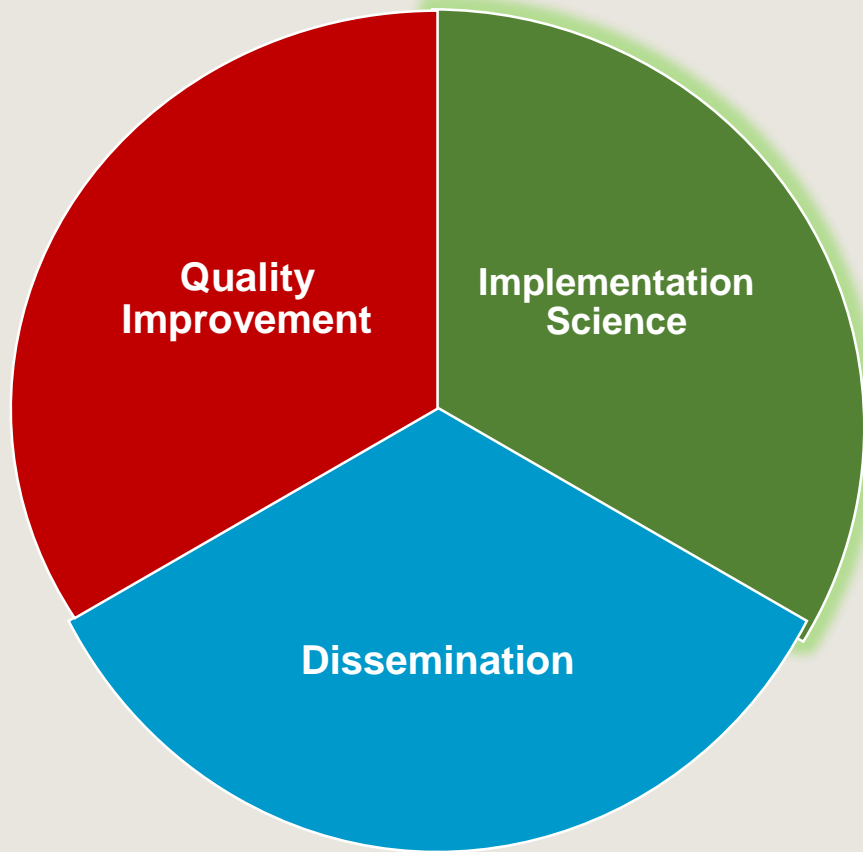
How do we ensure engagement, buy-in, adoption, implementation, commitment, sustainability



# IMPLEMENTATION SCIENCE

Implementation science is “the scientific study of methods to promote the systematic uptake of research findings and other EBPs into routine practice.” [2]

Implementation science is distinct from, but shares characteristics with, both quality improvement and dissemination methods. [3,4]



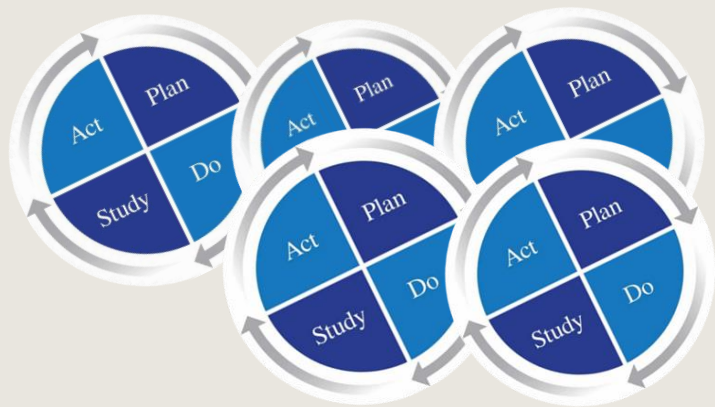


Framework for Improving Quality in our Health Service [5]



# INTRODUCTION OF BRIEF & DEBRIEF PROCESSES TO IEHG OPERATING THEATRES

A sub-group was established to design and pilot a process for implementation of the WHO Guidance, which advocates for a team Brief and Debrief to take place for **each theatre list** using ‘a **standardised template**’ and following a ‘**structured**’ approach.



The image shows two side-by-side forms: 'HSE Safe Surgery Team Brief' and 'HSE Safe Surgery Team Debrief'. Both forms include sections for Staff Present, Concerns raised, and Achievements and What Worked Well. The forms are designed to be filled out by the surgical team before and after the procedure.

The image shows two side-by-side forms: 'HSE National Policy and Procedure for Safe Surgery - Team Brief' and 'HSE National Policy and Procedure for Safe Surgery - Team Debrief'. Both forms include sections for Staff Present, Concerns raised, and Achievements and What Worked Well. The forms are designed to be filled out by the surgical team before and after the procedure.

Mirroring advice from Implementation Science research [4,6,7] a combination of interventions were adopted in order to implement the steps to safer surgeries:

- **Partnering** with theatre managers on **co-production of solutions**, availing of **local knowledge** from target population representatives.
- A series of **PDSA cycles** to optimise content of the Brief & Debrief templates, contributing to **ownership** and **engagement**. An overlapping series of PDSA cycles involving the printing company to develop and refine a book-type format
- Implementation of the book with the Brief & Debrief documentation, to act as a **physical reminder** to staff and as a **Forcing Function** within the daily routine
- **Piloting** in 3 sites, **trusting local problem-solving** to **tailor the process to the local context**
- **Facilitating and encouraging feedback** throughout the Pilot phase to **foster ownership and engagement**.

RESULTS: Consensus on the importance of the process with views expressed that it should be rolled out to all areas. **Some local informal leaders** emerged to drive implementation

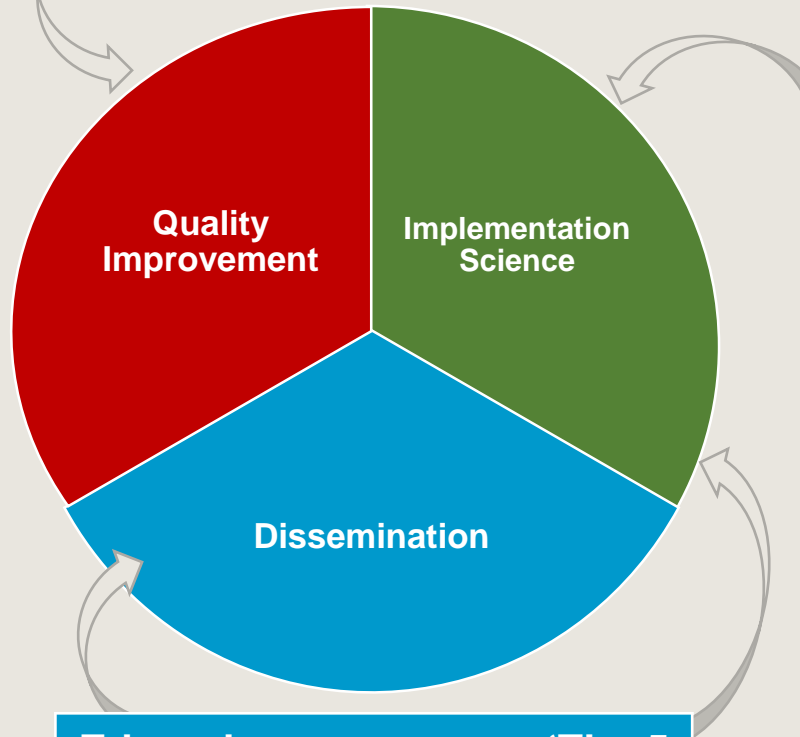
One site commented that the process implemented surpassed expectations.

LEARNING: The **need for sustained focus** and drive by leaders throughout the implementation  
**The importance of continuously engaging all involved.**



# NEXT STEPS

**National Audit  
Programme**



**E-learning programme 'The 5  
Stages of Safe Surgery'**

Engagement with sites to purchase a stock of the books to meet their needs  
Engagement with printing company regarding the production of the supply of books, reasonably priced and available in adequate quantities to meet demand  
Engagement with Theatre Users for the roll out of the initiative to all theatre areas

- Implementation Science is a necessary component in enabling us to 'continue the job of research' [8] supporting its implementation into practice

# THANK YOU

## References

1. Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J Roy Soc Med. 2011;104:510–20
2. Bauer, MS, Damschroder L, Hagedorn H, Smith J, Kilbourne AM. An introduction to implementation science for the non-specialist. (2015) BMC Psychology: 16;3(1):32.
3. Handley, MA et al. “Strategies for implementing implementation science: a methodological overview.” (2016) Emergency medicine journal : 33,9: 660-4.
4. Leeman, J., Rohweder, C., Lee, M. et al. Aligning implementation science with improvement practice: a call to action. (2021) Implement Science Communications 2, 99 <https://doi.org/10.1186/s43058-021-00201-1>
5. [framework-for-improving-quality-2016.pdf \(hse.ie\)](#)
6. O’Cathain, A., Croot, L., Sworn, K. et al. Taxonomy of approaches to developing interventions to improve health: a systematic methods overview. (2019). Pilot and Feasibility Studies 5, 41 <https://doi.org/10.1186/s40814-019-0425-6>
7. Cochrane Effective Practice and Organisation of Care Review Group. Data collection checklist: Cochrane Effective Practice and Organisation of Care, 2002. <https://epoc.cochrane.org/sites/epoc.cochrane.org/files/uploads/datacollectionchecklist.pdf>
8. Bauer, MS., Kirchner, JA. Implementation science: What is it and why should I care? (2020) Psychiatry Research, Volume 283,112376, ISSN 0165-1781, <https://doi.org/10.1016/j.psychres.2019.04.025>



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18<sup>th</sup> April, 2022

# Safer Surgeries...steps to reduce risk of harm

# QPS TalkTime



A community of quality and patient safety improvers

## Safer Surgeries...Steps to reduce risk of harm

### NCEC Clinical Guideline for



gov.ie

Departments

Consultations

Publications

#### Publication

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## Unexpected Intraoperative Life Threatening Haemorrhage

From [Department of Health](#)

Published on 16 May 2022

Last updated on 17 May 2022

*Dr Joan Power MB, FRCPI, FFPATH, RCPI Consultant Haematologist*

**April 18, 2023**

# QPS Safer Surgeries.....Steps to reduce harm

## *NCEC Clinical Guideline for*

## *Unexpected Intraoperative Life threatening Haemorrhage*

### Rationale

#### ❑ Life threatening haemorrhage-

- an adverse event of key concern in health
  - 23% intra-operative, 78% unexpected, 54% OOH (UK national Comparative Audit, 2018)
  - Blood loss > 40% blood volume is life threatening (1500-2000ml)  
requires immediate transfusion and management of associated coagulopathy
  - Associated mortality 10 - 11.5% (UK, RCSI survey 2018)
  - 32% mortality associated with delay to transfusion in MPH activation  
(UK Haemovigilance system **SHOT**)
- Ministerial Commission after fatal unexpected intraoperative LTH for  
National Clinical Effectiveness Committee (NCEC) to develop guideline

# QPS Safer Surgeries.....Steps to reduce harm

## *NCEC Clinical Guideline for Unexpected Intraoperative Life threatening Haemorrhage*

### ❑ Objective and scope

**Develop a National framework for management of adult unexpected intra-operative acute life threatening haemorrhage** (excluding obstetrics, trauma, post-op) **across all relevant services and professions in Irish Hospitals,**

*“.. to reduce unnecessary variations in practice and provide an evidence base for the most appropriate healthcare..”*

**consistent approach** to management across all service sites  
**underpinning structures and processes.**

### **Provide evidence based recommendations for theatre & laboratory staff**

guidance to theatre teams and associated healthcare professionals on recommended practices in the following areas -

- Prevention
- Immediate recognition
- Timely response and management



# QPS Safer Surgeries.....Steps to reduce harm

## *NCEC Clinical Guideline for Unexpected Intraoperative Life threatening Haemorrhage*

### ☐ Definition

**‘Anticipatory’** Clinical impact (shock) of on-going major haemorrhage (Vs ‘Retrospective’ Defined blood component use/ blood volume loss over time)

☐ activation following rapid identification of actual, or suspected, major haemorrhage, with/ without coagulopathy.

☐ Prompt response like any other resuscitation calls to ensure effective treatment is delivered without any delays to bleeding patients’ \*

### Factors contributing to MPH delays \*

#### Poor communication



Delayed Recognition ,unfamiliarity



Delay in Activating and accessing help



Patient movement



Laboratory delays



Blood Transfusion

\*S Narayan(Ed),D Poles et al on behalf of SHOT steering group report (2022)

# QPS Safer Surgeries.....Steps to reduce harm

## *NCEC Clinical Guideline for*

## *Unexpected Intraoperative Life threatening Haemorrhage*

### ☐ **management**

- **System approach-** Prevention and preparedness
  - Policies, protocols , communication and documentation
  - inc. Safe surgical site, patient transfer protocols,
  - Pre-op patient risk assessment and intervention, Surgical checklist individual case
- Timely access to transfusion support and appropriate TAT of laboratory testing **Management**

### ➤ **medical emergency**

- **Activate 'code red'**
- **Control bleeding**
- **Assess and resuscitate (ABC)**
- **Haemostatic resuscitation In defined communication pathway**
  - With optimal laboratory response , timely release of blood components of pre-determined red cell: plasma ratios (empiric transfusion- MHP pack) supported by haemostatic components (without approval of haematologist),
- **Close monitoring of patient** (clinical, cardiac, metabolic , laboratory testing / NPT\*) inc. Coagulation , fibrinogen q 30-60 mins

# QPS Safer Surgeries.....Steps to reduce harm

## *NCEC Clinical Guideline for*

## *Unexpected Intraoperative Life threatening Haemorrhage*

### Empiric Transfusion protocols

Support tissue oxygenation, aim to prevent/ reverse coagulopathy early by rapid transfusion in advance of results from blood science testing

#### Recommendation #12

##### ☐ Transfusion component, derivatives and pharmacological support

- **Tranexamic acid** Trauma CRASH-2 – reduced mortality  
PPH WOMAN study – reduces bleeding RIP by 1/3, no adverse effects  
(GI HALT-IT study- not indicated for GI bleeding – no reduction RIP , ↑VTE )
- **Red cells** – Provide critical life saving support, tissue oxygenation, assist coagulopathy
- **Plasma** - SD plasma - frozen (reduced coag factors x~ 15 % )  
central role in managing coagulopathy, protective of endothelium
- **Fibrinogen**- Key role for ↓ fibrinogen- early critical event,  
<1g.> 1-1.5bv loss/ replacement.  
insufficient in plasma, ROI Fibrinogen concentrate
- **Platelets**- Consider use for ↓plt- late event > 1.5 bv loss  
but timeline to access variable across hospitals
- **Reversal of anti-coagulation**

# UNEXPECTED ADULT INTRA-OPERATIVE LIFE THREATENING HAEMORRHAGE PROTOCOL



CLINICAL CONCERN FOR LIFE THREATENING BLEEDING  
THEN ACTIVATE **CODE RED IMMEDIATELY**



## SENIOR CLINICIAN

STATE - I am activating the Life Threatening Haemorrhage Protocol, **CODE RED**

## IDENTIFY EMERGENCY COORDINATOR

Co-ordinator function, Delegate & assign roles, Mobilise resources

## STOP THE BLEEDING

- › Identify bleed
- › Source instruments
- › Midline laparotomy
- › Damage Control via
  - Direct Pressure
  - Packing
  - Clamping

## RESUSCITATE

### Airways/Breathing/Circulation

- › Large bore IV access  
2 x 14 gauge
- › Supply appropriate  $f_iO_2$  to maintain good oxygenation
- › Continuous Cardiovascular monitoring
- › Active/passive warming – environment, fluids, blanket

Identify if anti-coagulated,  
on anti-platelet meds  
and discuss reversal with  
Haematologist

## MANAGE METABOLIC RISKS

Hypoxia, Hypothermia,  
Hypocalcaemia, Acidosis,  
Hyperkalaemia

## IDENTIFY COMMUNICATION LEAD

- Keep Emergency Coordinator informed
- Identify yourself and your contact number

## CALL FOR HELP

State Life Threatening Haemorrhage  
Protocol activated **CODE RED**  
in location xxxxx for patient yyyyy

- › Switchboard TEL/EXT: \_\_\_\_\_
- › Surgeon TEL/EXT: \_\_\_\_\_
- › Anaesthesiologist TEL/EXT: \_\_\_\_\_
- › Laboratories - Blood Transfusion, Haematology, Biochemistry
- › Porter
- › Assistant Director Of Nursing
- › Haematologist as required
- › Additional Support/ External Help if needed (e.g. Vascular surgery or Interventional Radiology)

## CONTACT TRANSFUSION LAB, PLAN BLOOD SAMPLES AND TRANSFUSION SUPPORT

- › Identify sample requirements and blood component availability
- › Take Bloods and send to laboratory/ Near Patient Testing (NPT)
  - Blood group & antibody screen, FBC, U&E, Calcium, Coag screen inc. fibrinogen, lactate, ABG

## PAUSE AND REVIEW

## REPEAT BLOODS

- › Repeat FBC, U&E, calcium (Ca), coag screen, fibrinogen at 30 mins then hourly
- › Inform laboratory of NPT results

## STAND DOWN

Inform Lab / Return unused components / Complete traceability & documentation / Start thromboprophylaxis / Plan de-brief

## 1 INITIAL EMPIRIC BLOOD MANAGEMENT

TRANEXAMIC ACID -  
1g IV bolus over 10 mins  
Consider Cell salvage -  
if in regular use

IMMEDIATE RED CELL  
TRANSFUSION  
TRANSFUSE Emergency Group O  
(or patient specific blood order  
if available) from nearby blood  
fridge/ transporter

## EMPIRIC BLOOD MANAGEMENT (THEN TRANSFUSE GUIDED BY LABORATORY/NEAR PATIENT TESTING)

ORDER MASSIVE  
HAEMORRHAGE PACK  
4 units of red cells  
4 units of Plasma

ORDER 4g fibrinogen for every blood  
volume loss

REQUEST PLATELETS TO BE AVAILABLE  
ON STANDBY - TRANSFUSE 1 UNIT  
(ADULT DOSE) OF PLATELETS FOR 1.5  
BLOOD VOLUME LOSS OR GUIDED BY  
PLATELET COUNT TO KEEP  
PLATELETS  $> 50 \times 10^9/L$

## PAUSE AND REVIEW

IF BLEEDING  
CONTINUES  
REASSESS  
AND CONTACT  
HAEMATOLOGIST

Consider  
10 ml  
10% Calcium  
gluconate

Order additional Massive  
Haemorrhage Packs/transfuse  
guided by test results  
and repeat monitoring until  
bleeding controlled

TREATMENT TARGETS  
Hb  $7-9g/dL$  / Platelets  $> 50 \times 10^9/L$ ,  
PT/APTT  $< 1.5 \times$  mean control /  
Fibrinogen  $> 1.5g/L$ ,  
iCa++  $> 1 mmol/L$

VERSION 2 JANUARY 2023

NEAREST EMERGENCY GROUP O	BLOOD FRIDGE/ TRANSPORTER	RED CELL COMPONENTS	PLATELETS	PLASMA	FIBRINOGEN	TRANEXAMIC ACID (TXA)	PROTHROMBIN COMPLEX CONCENTRATE	IDARUCIZUMAB (PRAXBIND)
Location		Time to availability Patient's own group	Location	Location	Location	Location	Location	Location
Minimum contents		Cross matched	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability

Date Hospital Specific  
Information updated \_\_\_\_\_

Supplied as Available

For Anticoagulated Patient

NATIONAL TRANSFUSION ADVISORY GROUP (NTAG)  
<https://www.gov.ie/en/publication/05800-unexpected-intraoperative-life-threatening-haemorrhage/>

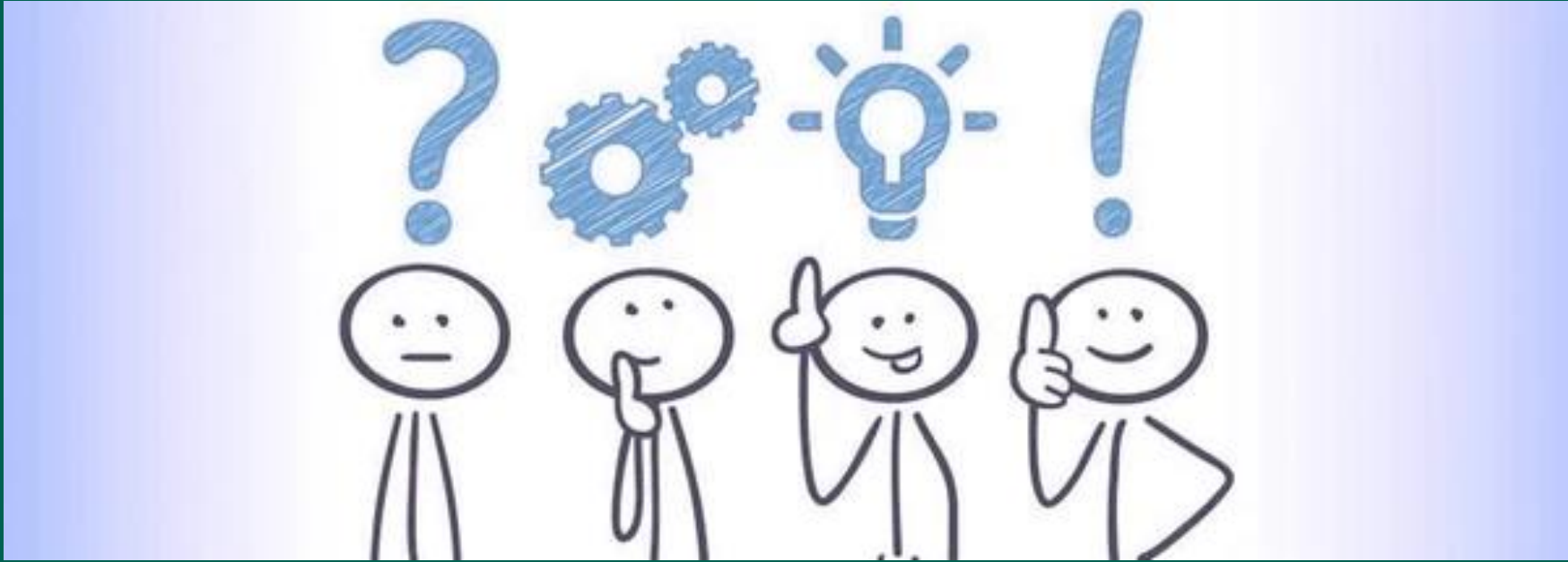
-Communication to  
hospital Managers/  
CEOs to id responsible  
person lead roll-out at  
each service site  
(National Quality &  
Patient Safety  
Directorate)

-Circulation of Poster to  
hospitals

-Engagement with local  
stakeholders for Local  
data capture on Posters

Poster display in each  
relevant surgical  
site/room

Will be supported by  
on-line guide, FAQs

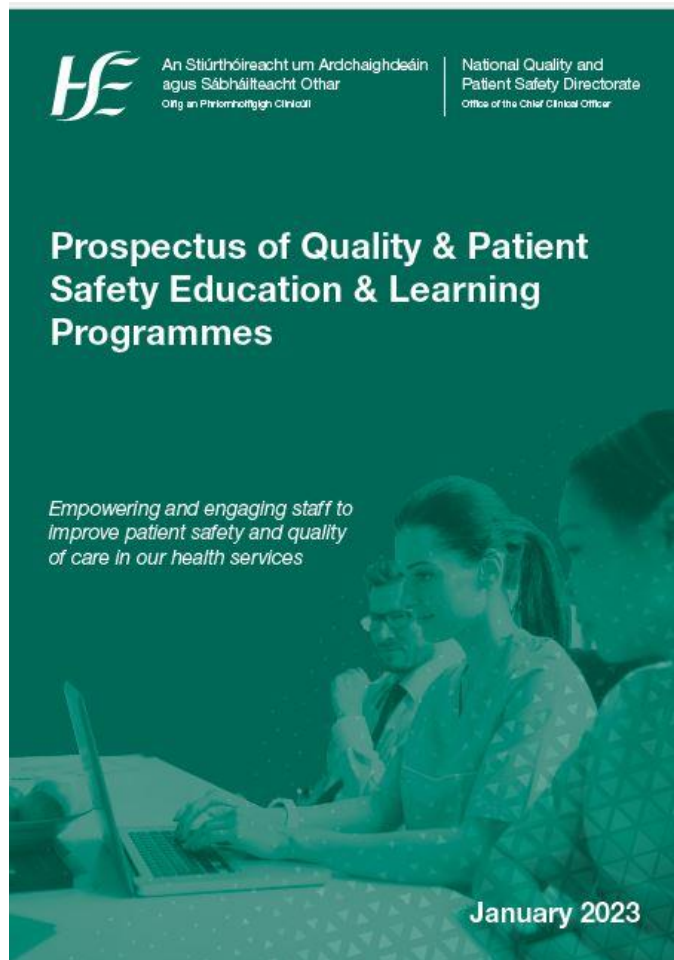


# HEARING YOUR THOUGHTS AND COMMENTS





# Quality & Patient Safety Prospectus 2023



## Table of Contents

- Quality Improvement
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- Safeguarding
- Antimicrobial Resistance & Control (AMRIC)
- Change & Innovation
- Library Services
- Connecting with QPS



<https://www.hse.ie/eng/about/who/nqpsd/qps-education/prospectus-of-education-and-learning-programmes.html>





# Human Factors Learning Programmes

**Introduction to Human Factors**

Version 07 last reviewed 13/1/2023

**Let's begin**

20 min e-learning module available on HSeLanD.

## Topics

Definition of Human Factors

History of Human Factors

Key factors that impact on performance & wellbeing

Human Factors in practice

**hseland.ie**  
Cúram le Eolas

**COMING SOON**

## Foundation in Human Factors

1 day workshop for Teams

### Topics

Human Factors as a new way of thinking  
Factors impacting on human capabilities and limitations

Threat and error management.

Information processing.

Effective decision making and communication.

Non-technical skills assessment using behavioural markers.

Management and leadership.

Human Factors in healthcare.

For further information, [qps.education@hse.ie](mailto:qps.education@hse.ie)



# RCPI SAFE Collaborative

**Applications will open shortly** for the next cohort of the RCPI SAFE Collaborative, funded by the National QPS Directorate and commencing in Sept 2023

- Multidisciplinary clinical teams of 4 from frontline healthcare
- Improve safety, communicate effectively, heighten recognition & response in your setting

Want to learn more? Contact  
[QPS.Improvement@hse.ie](mailto:QPS.Improvement@hse.ie)

The graphic is a dark blue rectangular poster. At the top left is the Royal College of Physicians of Ireland logo. At the top center is a gold circular seal with the text 'YOU'RE INVITED'. At the top right is the HSE logo. Below these is a teal rectangular box containing the event details. At the bottom is a white rectangular box with a gold border containing additional information.

**ROYAL COLLEGE OF PHYSICIANS OF IRELAND**

**YOU'RE INVITED**

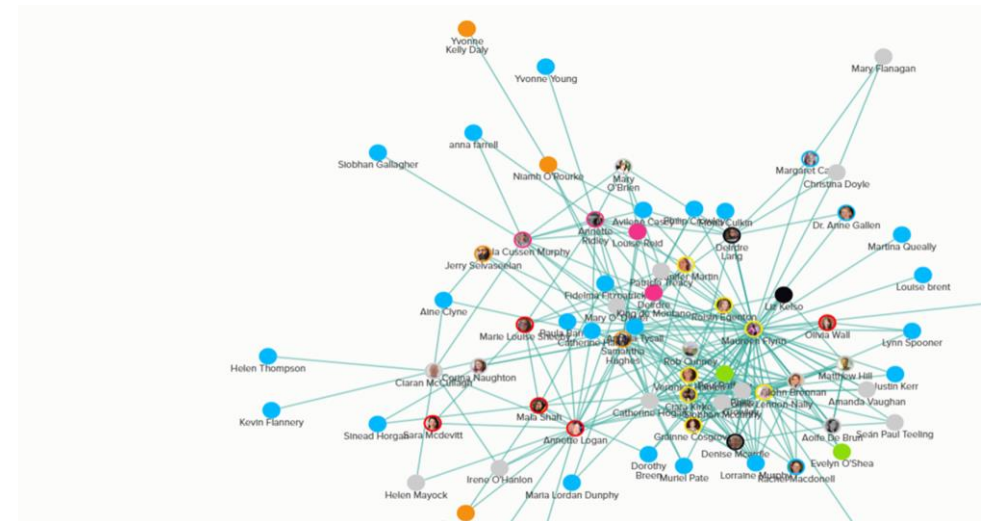
**Situation Awareness For Everyone:  
Sustain and Spread your Huddle & Deliver  
National Patient Safety Priorities**  
**4 May, 2023**  
10 AM – 4 PM - 6 CPD awarded  
**RCPI, No. 6 Kildare Street**

Open to all previous SAFE learners, free of charge.  
Please join us for a day of shared learning,  
keynote speakers and a focus on supporting you to  
sustain your Huddle improvements and spread the  
changes to other settings. Agenda to follow.

# 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



## About

We are a community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care. Q is delivered by the Health Foundation and supported and co-funded by partners across the UK and Ireland.



Q-Membership is not needed to join the Patient Safety Community, but we encourage anyone with an interest in quality and patient safety to explore all the supports freely available on the Q Community Website: <https://q.health.org.uk/join-q/>

For information on how to apply contact:  
[Mary.lawless@hse.ie](mailto:Mary.lawless@hse.ie) / [Roisin.Egenton@hse.ie](mailto:Roisin.Egenton@hse.ie)



# Upcoming Webinars: Dates for your diary ....



**Mila Whelan**

Partnering with Patients,  
Operational Performance &  
Integration



**Nicola Williams**

Partnering with People who Use  
Health Services Programme



**Patrick James Power**

Member of the HSE National  
Patient Representative Panel



**Brid Ryan**

Clinical Lead ePharmacy

## QPS TalkTime



A community of quality and patient safety improvers

## QPS TalkTime No. 7

2<sup>nd</sup> May 2023 | 1pm to 2pm

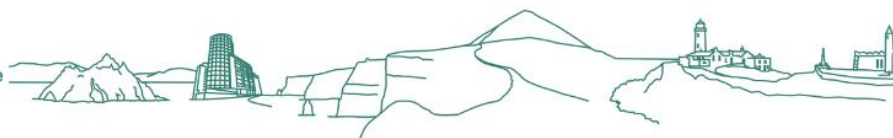
# Patient Partnerships

Scan me!



An Stiúirtheoireacht um Ardchaighdeáin  
agus Sábháilteacht Othar  
Oifig an Phríomholltigh Cliniciúil

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



# Connect with us

**QPS TALKTIME**



Building an Irish Network of Quality improvers



**@QPSTALKTIME**

Follow



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An Stiúrthóireacht um Ardchaighdeán agus Sábháilteacht Othar  
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*Thank  
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**Contact:** [Kris.Kavanagh@hse.ie](mailto:Kris.Kavanagh@hse.ie) to be included on our mailing list to receive QPS TalkTime invitations