An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

Patients for Patient Safety Ireland

QPS TALKTIME

A community of quality and patient safety improvers

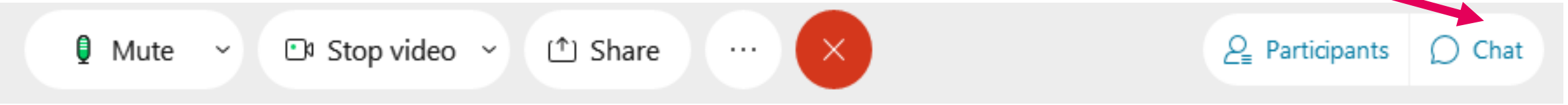
15 February, 2022

Our Healthcare Service includes everyone: Reflections from Patients for Patient Safety Ireland

CONNECTING PEOPLE INTERESTED IN QUALITY AND PATIENT SAFETY | https://www.hse.ie/eng/about/who/nqpsd/ | @QPSTalktime | @NationalQPS | #QIreland

Welcome

- **Sound:** Computer or dial in:
  - Telephone no:
    - Irish: 01-5260058
    - UK: +44-20-7660-8149
  - Event number: 2734 100 0105#
- **Chat box function**
  - Comments/Ideas
  - Keep the questions coming!
- **Recording**
- **Engage with the team**
  - Twitter: @patients_for @johnfitzsimons9
  - @QPSTalktime /@NationalQPS/ #QIreland #patientsafety
- **Feedback**
  - Short feedback form after the session, please help us to improve our QPS Talktime Webinars
  - A window will pop up before logging out
- **Confirmation of attendance**
  - You will receive an email from QPS Talktime



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:

"I think the point of patient partnership is…"

Speakers today

Bernie O'Reilly, a member of Patients for Patient Safety Ireland and former Chairperson. Bernie is a believer in the active participation of patients/service users, their families and carers in quality improvement for safer healthcare.

We are all better working together.

Mairie Cregan, a member of Patients for Patient for Safety Ireland and co-founder of Feileacain (Stillbirth and Neonatal Death Association of Ireland). Mairie believes in including the experience and the voice of patients in strengthening our health service.

In conversation with

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

Patients for Patient Safety Ireland (PFPSI)

- Patients for Patient Safety is a WHO worldwide network of patient champions. Established in 2004 with signing of the London Declaration.
- Brought to Ireland in 2013 by Margaret Murphy, External Lead Advisor, WHO, Patients for Patient Safety Programme, one of the original 24 signatories of the London Declaration.
- A collaboration between patients, their families, carers and the HSE
- For more information: http://patientsforpatientsafety.ie/ and https://www.linkedin.com/in/patients-for-patient-safety-ireland-join-us-in-our-work-6297371b7/

World Health Organization

HSE

PFPSI Members

- Members are people with stories of harm.
- Their own story or that of a loved one.
- Shared in the spirit of learning and to bring about improvements in patient safety.
- Volunteers. Ordinary people from all walks of life.
- We welcome new members or any queries to email: info@patientsforpatientsafety.ie

WE ALL WIN WHEN PATIENTS SPEAK UP

Its our health service, and we all bring some knowledge, professionals bring skills, patients and service users bring their lived experience. Families and carers are part of the patients/service users support network and see the impact of healthcare on their loved ones, becoming the voices of the vulnerable and voiceless.

OUR PART

PFPSI Members are more than their stories of harm, the outcomes of which cannot be changed for us.

We are active participants in building a stronger, safer, fit for purpose health service.

Bernie's Story

My husbands death from Septic Shock following surgery in 2006

- Tony was a healthy athletic 50 year old man who by his own admission **"never felt better in his life"**
- He was having elective surgery - bowel resection to remove a tumor, no complications anticipated and a full return to normal life expected
- Actual outcome

  Operation Monday

  Death from septic shock Thursday

  72 hours from fit person to life gone.

What Happened?

I will most likely never know all the facts of what happened.

- Surgical Team were on call in a Dublin hospital – slotting in elective surgeries
- Traffic Accident Victim arrived in hospital and was assessed by Tony's surgeon as not in need of his skills
- Tony's operation commenced.
- Just over an hour in the accident victim became critical
- **Team left my husband** to attend accident victim for an undisclosed period **approx. 2 hours 15 mins.**
- **No operating took place on Tony during that time.**

So my husband lay there

waiting.

- During this time Tony received 4 units of blood.
- Surgeon and his attending returned and completed surgery.
- Within 24 hours Tony was unwell.
- By Wednesday lunchtime he was in serious trouble – bloods tests which showed the gravity of this were **dismissed** as perhaps from a "drip arm" and repeat bloods were not treated as urgent.
- **NO ONE JOINED THE DOTS TO SEE SEPSIS UNTIL IT WAS TOO LATE**

What next ?

- Me and my 18 year old daughter were pretty much abandoned by health service – Death from Sepsis – risk of surgery… bad luck
- Surgeon conjectured that the staple gun failed.
- Inquest – medical professionals reported – normal busy day in a Dublin Hospital and a possible malfunction of a stapling device
- No one batted an eyelid about the 2 hour gap.
- Johnson & Johnson – devices tested from same batch gave normal presentation of appropriate function.
- Us – lots of questions – very few answers.
- Verdict; Cause of Death - Septicemia – Anastomotic Leak - Defective Instrument (Surgical)

Learning to live in a new way

- I waited to see what would happen next. Nothing.
- Then I explored the legal route to getting answers – that was expensive and in the end I gave up. Afraid I would loose our home paying legal bills.
- Then I wrote a letter to Mary Harney TD and fair play to her she sent it to the HSE
- A Year later there was an External Review of Tony's care. It was a genuine effort and I am grateful – but it was too long after Tony's death. People had forgotten and moved on.

THE NEXT BIT

- In February 2015 I was introduced to Patients for Patient Safety, Margaret Murphy and her group of patient voices.
- Its been varied – some great opportunities , a chance to understand our healthcare system – its strengths and its weaknesses.
- Its easy to take on too much and get overwhelmed.
- Out of my depth – a lay person in a world of academics and healthcare professionals. But maybe people need to hear our stories, and feel unsettled and work for better outcomes, and we need to see the good work and challenge the systems that fail people.

What I get involved in as a member of Patients for Patient Safety

- Sepsis awareness
- Open Disclosure – Member of the National Steering Group
- Infection Prevention and Control. Member of NCEC IPC new guidelines group.
- NPHET – for CPE one of two patient representatives on both NPHET and the Expert Group for CPE
- Safe Site Surgery Group
- Member of HSE People and Culture Committee.
- iSimpathy (Polypharmacy)Project – steering group member.
- Patient Engagement Framework Group
- Presenting my story as a PFPSI member at conferences, and tuning into virtual webinars of interest to me and our group
- former Secretary and Chairperson of the group.

Mairie

Founder of the Aurelia Trust – Organisation promoting the development of Alternatives to Institutions in Eastern Europe

Co-Founder of Feileacain (Stillbirth and Neonatal Death Association of Ireland

- Listening – and hearing – patients makes a difference in delivering high quality care
- Reduces harm and promotes healing
- Lessens feelings of powerless, anxiety and despair
- Examples…

Mairie's reflections:

- Why PFPSI for me?
- The concept of *Partnership* what did this mean?
- How could I contribute – standing on the shoulders of others
- All of our members have been harmed in some way by our treatment in the health services
- But we have also witnessed health care as it should be – and *could* be

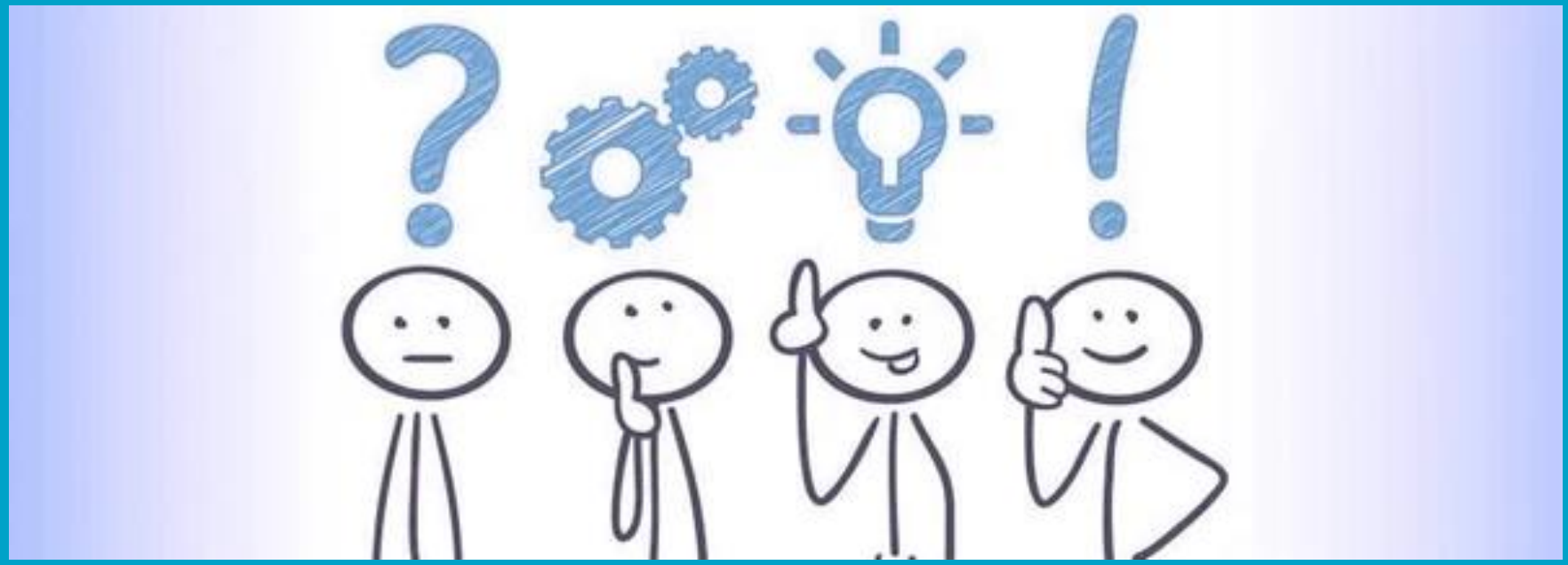
What is the Point of Patient Involvement?

- Context of Patient Involvement
- Might be great in practice – but how can we get it to fit the theory???
- Involving patients requires a readiness to engage – and to change
- How do we (PFPSI) support *real* patient involvement – what's our role?
- Appropriate representation

Vital to Involve Patients in their Care

- Afraid of feedback?
- Vulnerabilities…
- Empowering clinicians to become partners with patients
- Share Knowledge

Five minutes of good compassionate care is priceless to a vulnerable patient –five minutes of poor, off-hand care will last for long long time or the same person



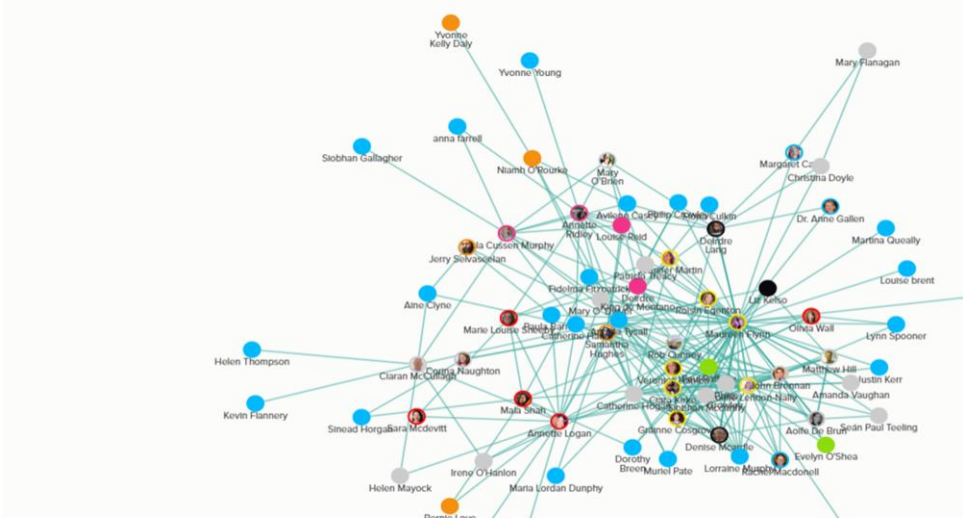
HEARING YOUR THOUGHTS AND COMMENTS

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 ….

Dates	Topics	Speakers
1 March	Partnering with patients	Mila Whelan, Anne Lawlor and Nicola Williams, HSE National Patient and Service Users Forum
22 March	Liberating Structures	Dr Rob Cunney, Medical Microbiologist and QI and Clinical Safety Lead, Children's Health Ireland at Temple Street.

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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