An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer
Edition 1 April 2023
Quality and Patient Safety
MATTERS
#AllThingsQuality
First meeting of the
Patient Safety Community
Reducing
Surgical Site Infection
Featuring
TOP TIPS FOR EFFECTIVE PATIENT PARTNERSHIPS WITH JOAN JOHNSTON
A newsletter from the National Quality and Patient Safety Directorate

A message from the editorial team

Welcome!

It is a pleasure to welcome you as a reader to our first edition of the Quality and Patient Safety Matters #AllThingsQuality newsletter. This quarterly newsletter started because you told us you wanted to read about quality and patient safety (QPS). In each edition, we will share QPS news, your QPS stories, educational content and upcoming training, events and networking opportunities.

We will be connecting with patient partners in each publication to bring an insight about their role, passions and the potential their involvement brings in QPS work. In this edition, we are delighted to be joined by Tiberius Pereira, Patient Partner, Patients for Patients Safety Ireland. Tiberius shares information about My Medicines List - an invaluable resource for people with medication needs. We are also joined by Joan Johnston, Patient Partner who shares her top tips for involving patients in health services delivery.

You can read stories on Electronic Point of Entry in Donegal, Dublin and Wexford, improvements in surgical site infections in Cork, electronic traceability of transvaginal / rectal probes in Dublin and making mobility and falls everyone's business in Kerry.

We hope you enjoy our article on how to access free educational content to develop your QPS skills. There is something for everyone, whether you are starting out or seeking to further develop your expertise. We also have updates on Patient Safety Together, open disclosure, human factors and so much more.

You do not have to be a quality expert to read this newsletter or access the resources we share. We want it to be a newsletter for every staff member or patient partner who has an interest in improvement. When you are working in healthcare, you are working to improve the services for everyone, including yourself, your family and friends. We hope that this newsletter will both inspire and guide you as you do this work.

Most of all, we want to hear from you, so please share your thoughts, ideas and stories with us for future editions.
See page one to find out how.

Best wishes,

Juanita Guidera
Editor

Sheema Lughmani
Deputy Editor

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#AllThingsQuality
#QIreland
#PatientSafety

If you would like to share your ideas for content in Quality and Patient Safety Matters, Edition 02, July 2023 please complete the survey below.

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

Within the National Quality and Patient Safety Directorate, our vision is that all people using health and social care services will consistently receive the safest care possible and the highest quality service.

A key part of creating an organisation focused on quality and patient safety is making it accessible. Hearing stories of improvement, knowing about upcoming educational and networking opportunities and being aware of recommended practice are an important element of this. We hope that this newsletter will become a key resource for you, whether you are a patient partner, a member of the quality and patient safety community, a leader in healthcare or a staff member interested in and influencing quality and patient safety daily.

The newsletter is an interactive PDF and we have included hyperlinks where relevant in each article. When you click on a hyperlink, it will bring you directly to the webinar, registration link, training, 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:

Thank you to all who contributed to this publication which we hope captures a taste of the work happening in the system. We hope you enjoy reading it and we look forward to not only hearing your feedback, but also your ideas, suggestions and contributions to future editions.

Best wishes,

OHealy

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

Top tips for effective patient partnerships

Are you interested in involving patients in your work in a way that will truly influence change? If so, these top tips from Joan Johnston, Patient Partner are full of wisdom and common sense. Joan shares some of her learnings on how your service can work with patient partners to create meaningful improvement.

Joan has been a patient partner on the management team of the National Quality and Patient Safety Directorate since 2022. She is also a member of the HSE Board - Performance and Delivery Committee with patient / service user expertise.

Pictured above and on our front cover of this edition of Quality and Patient Safety Matters, is Joan Johnston. Joan is pictured with her son Leo whose beautiful smile and sense of fun radiate from the photo. Joan became involved as a patient partner after Leo was born with Angelman syndrome, a rare neurogenetic condition.

Who are patient partners?

Patient partners are members of the public who represent the views of patients, their families and the general public, and provide meaningful contributions to healthcare delivery.

How can you maximise relationships and fully engage with patient partners?

Go beyond patient engagement, establish a partner partnership

Patient engagement can be quite narrow and can sometimes mean simply having a patient in the meetings, some who might not have the relevant knowledge about the issues being discussed. Patient partners have lived experiences, or represent groups with shared lived experiences, that can provide greater insight.

Where possible, bring patient partners in at the very beginning

If patient partners are involved from the onset of the work, they will understand the role, work and goals of your project much better and can contribute in a more meaningful way.

Ask about the interest and skills of patient partners beforehand

Have a conversation about their interests before providing partnership opportunities to see if the work aligns with their interests, experiences and skills. That can make the difference between engagement and partnerships.

Provide the necessary training, education and resources patient partners may need

If you want patient partnership to have a real impact, ask: "What particular training might be helpful in fulfilling this role? Is this something you need?".

Patient partners will have different skills, experience and education. Provide opportunities for your patient partner to learn what they need to know about your service and organisation, project, etc. Investing in your patient partner shows that you view them as a critical part of the work.

For more information on patient partnership, you can watch the upcoming @QPSTalkTime on 2nd May 2023 at 13.00. The session will be recorded and will be available on our youtube channel to watch back...

Register through our website.

Two is always better than one

Patient partners volunteer their time - they may have jobs, families and other obligations. Having at least two patient partners means you're not asking too much of anyone person. It also allows for multiple perspectives.

Communicate the goals and potential scope of the work being asked beforehand

This may include time commitments or any timelines you may have for your project. This also includes how you anticipate communicating with them. Will there be in-person or virtual meetings, calls, and emails?

If patient partners have a clear sense of what they are agreeing to, they are more likely to stay on and complete the project. If a project has been paused, give an update. This may not fall within the timeframe they were anticipating so it's important to reassess and check-in.

Provide transparency

If you have decided not to use the suggestions they have shared, share your reasons why. Whatever the reasons may be, it's important for your patient partners to know they are being heard, even if certain suggestions may not work within the larger context of your organisation, service or project.

Say thank you!

A simple thank you, both during the journey and at the end of a project goes a long way and also makes it more likely for them to engage again in the future.

Date for your diary:
Sunday, 17th September 2023

World Patient Safety Day

Theme: "Engaging patients for patient safety"

This theme recognises the crucial role patients, families and caregivers play in the safety of healthcare.

A simple action YOU can take to reduce harm caused by medication errors

#KeepYourMedicinesList

Tiberius Pereira
Patient Partner
Patient for Patient Safety Ireland

Why is a medicines list important?

HIQA estimates that "…one medication error occurs per hospital patient per day, equating to three million medication errors in Irish hospitals per year."

Patients for Patient Safety Ireland are calling on healthcare professionals, including pharmacists, to advise patients and service users to keep a medication list.

The list can greatly improve the flow of information both ways and a list is easier than relying on memory alone.

What is a medicines list?

A medicines list is a list of all medicinal products patients are currently taking. It is compiled by the patient and includes prescription and over the counter medications, vitamins, supplements, and alternative medicines. It also includes all relevant details of dose and frequency. Some patients may presume that healthcare professionals have this information. Keeping a hard copy or a photo on a smart phone are both good ways to make sure it is always to hand.

How is it used?

The person shares the list with healthcare professionals at appointments or whenever they are asked about their medications. It can also be used to ask for clarity on any medication questions or unexpected symptoms of concern to the person.

What can YOU do to support the 'Medication Without Harm' initiative?

Distribute the HSE My Medicines List leaflet widely to all patients:

- Around the premises, in patient packs and in every interaction with patients.
- Help your patient to complete their list.

You can access the resources below by hovering over the text and clicking the hyperlink.

Print the Medication List form with every letter and communication sent to patients.

Put up posters around the premises.

Display the animated video on screens.

Tiberius Pereira is a co-founder and former Chair of Patients for Patient Safety Ireland (PFPSI). PFPSI is 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 healthcare services safer worldwide.

Its mission includes engagement for quality and safety through people-centredness and universal access. Engaging and empowering people is one of the five strategies of the WHO global strategy on people-centred and integrated health services (PCIHS) and a key element of quality Universal Healthcare.

Patients for Patient Safety Ireland is always seeking new members. For more information, email info@patientsforpatientsafety.ie. You can also access the following webpages for more information

Patients for Patients Safety Ireland
World Health Organisation

Patients and staff working together to reduce surgical site infection rates in Cork University Hospital

In conversation with Sinéad Horgan
Group Assistant Director of Nursing: Sepsis, Surgical Site Infection Surveillance and Flu, South / South West Hospital Group

Pictured below from left to right
Photo 1: The surgeons, porter, nursing and administrative staff.
Photo 2: Brian O'Connor, Valentia Island, Co Kerry (patient partner) after meeting with some of the team on his visit to Cork University Hospital
Photo 3: The wider team who make change happen in Cork University Hospital

Can you tell us a little about how this work started?

In 2018, the Colorectal Team in Cork University Hospital (CUH) in collaboration with the South/South West Hospital Group ADON for Surgical Site Surveillance initiated a project to identify the surgical site infection rate (wound infection rate) for their patients undergoing bowel surgery. The aim was to introduce quality improvement initiatives to reduce the occurrence of infections.

The 18-month long project resulted in the successful reduction of infection rates by 60%.

What do you think contributed to the success of this work?

The project identified that clear, concise patient information was a critical factor to contributing to the reduction of infection rates and improving the patient's experience of the colorectal service.

One of the key quality improvement initiatives agreed by the team was the design and development of a patient information booklet in 2018. The team shared the same goal that "all patients would get the right care at the right time in the right place".

Who was involved in developing the booklet?

All staff contributed to writing a 48-page information booklet. It was reviewed by five patients who gave their feedback.

Before being printed, the National Adult Literacy Agency checked and approved the booklet to ensure that it could be understood by people with a reading age of 11 years.

Tell us a little about the booklet

This booklet titled "Your guide to Bowel Surgery at Cork University Hospital" has been distributed to all colorectal surgical patients since it was launched in 2019.

The booklet provides information on wound care, diet, medications, pain management, exercise and how to return to normal activity after surgery. It is given to patients when there is a decision to operate. The booklet also gives information on what to expect while awaiting surgery, their stay in hospital and after they go home. It takes the patient through every step of their journey with excellent graphics and photographs.

The team wanted to ensure that patients had access to important information about their surgery and to serve as a guide before, during and after the process.

Has this work sustained? Is the booklet still in use?

After three years the team came together to seek feedback from patients who had used the booklet. In Autumn 2022, a survey was sent out to patients who were asked to complete a questionnaire with recommendations to improve the service for future patients.

The booklet was edited and reprinted taking into account the feedback from the patients. Patients suggestions included: more information on diet, wound care and activity after surgery. Once again, the Plain English stamp of approval was awarded to the booklet.

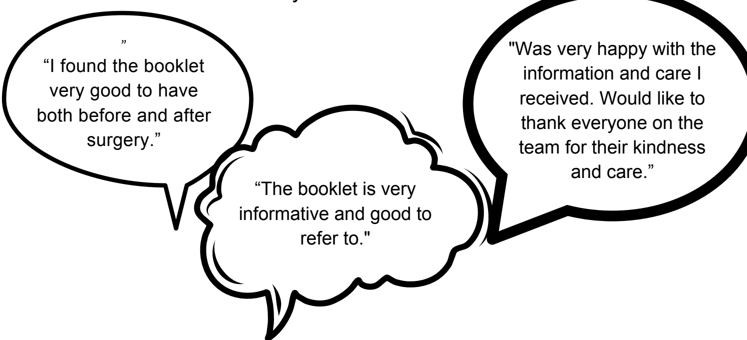
What did staff say about this work?

The CUH team share a passion for providing the best care for patients. This work shows how they value the voice of the patient by including them to improve how they deliver care to future patients. Anne Murphy, Advanced Nurse Practitioner commented:

"The whole team were very enthusiastic about their involvement in this project and very proud of the booklet. It is a privilege to have the voices of patients and staff collaborating on a project that makes meaningful changes for better outcomes. The end result; better care, happier patients, improved staff skills and morale."

What did patients say about this work?

93% of patients were satisfied with the level of care they received and 89% found the booklet very beneficial.



Where can you get more information?

This innovative method to improve infection rates has been shared with other hospitals across the country. To find out more you can contact Sinead Horgan Sinead.Horgan@hse.ie.

You can also read about the impact of the interventions undertaken in the Journal of Clinical Nursing (open access).

Recent introduction of electronic traceability system for decontamination of transvaginal/rectal probes in Beaumont Hospital

In conversation with Kevin Owens
Deputy Decontamination Manager Beaumont Hospital, RCSI Hospital Group

Why did you start this work?

In healthcare we never want things to go wrong but the nature of the work means that it can be high risk. All re-usable medical devices carry a risk of causing cross infection of patients. To reduce the likelihood of this risk materialising, we need to be able to recall accurate, reliable information on specific devices if an alert is raised. Sterile service departments and endoscopy decontamination suites have used electronic traceability systems to record these processes for years and national traceability systems exist in both areas. Unfortunately, ultrasound probes have had no such system in place and typically manual log books are used to record this vital information.

Our own HSE Guidelines for Decontamination of Ultrasound probes state clearly each "organisation should work toward implementing an electronic tracking system". With all of that in mind, it made the decision to pursue this quite simple.

How did you go about it?

The first thing we identified was that we needed a software package that was compatible with our service. We employ an automated high-level disinfection solution to process our probes and any traceability software would need to capture the information from this machine.

After some research we found a system that was compatible, easy to use and would provide the accuracy we were looking for, for every patient, every procedure, every process, every time. The machine used for disinfection sends a record of the process and its parameters to a cloud-based archive.

All of our probes carry a radio-frequency identification (RFID) tag and at a patient's bedside, this is taped to a handheld device which draws the decontamination record from the cloud and matches it to the individual patient procedure. In Beaumont Hospital we are very fortunate to have a hard working IT department who put a lot of technical wizardry in place, ensuring the software went live in a very short period of time. This, alongside specific training delivered by the software developer made for a very smooth introduction for staff in the Ultrasound department.

What are the benefits of this quality improvement?

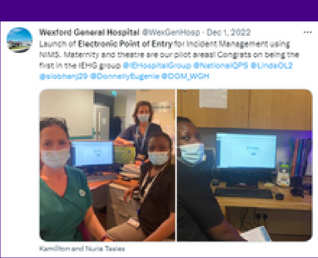
- Patients can be assured the probe is safe prior to use.
- No more hastily scribbled notes for staff in the log book.
- Managers can use the software to understand department productivity.
- The data is ready at the click of a mouse if something does go wrong and information needs to be recalled.

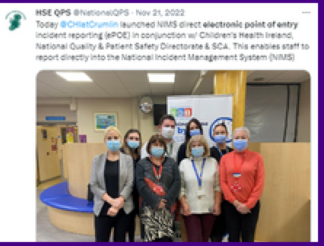
What are your top three tips for others starting a similar process?

1. Meet your team early to understand their ideas / fears about the project and discuss openly as a group
2. Data is key - provide measurement to demonstrate improvement and to convince others of the benefits
3. Trial then spread - start in one small location, if successful rollout the learning to other areas

Where can you get more information?

For more information contact: KevinOwens@beaumont.ie.





NIMS Electronic Point of Entry (ePOE) incident reporting

Electronic point of entry reporting is where frontline staff enter incidents directly onto the National Incident Management System (NIMS) eliminating the need for paper reporting.

To date, HSE and HSE-funded services across Ireland have relied on either a paper-based reporting system or secondary software to capture incident data before manually inputting them onto NIMS.

NIMS has the functionality that will allow services to manage incidents through the incident lifecycle on a single platform. The significant benefit of the national platform is that there is the opportunity for wider system learning. What might seem like a once off event within your service might be happening on a wider scale.

Where can you learn more?

You can find more information on our website.

You can also watch the @QPSTalkTime Webinar.

Pictured left are colleagues in Letterkenny University Hospital, Wexford General Hospital and Children's Health Ireland with members of the National Quality and Patient Safety Directorate and State Claims Agency working to implement ePOE in their services.

Making mobility and falls in University Hospital Kerry everyone's business

A Plan Do Study Act (PDSA) Cycle in progress by Amanda Brolly, Registered Advanced Nurse Practitioner in Frailty (RANP), University Hospital Kerry

Falls in hospital can be detrimental to patient safety. In University Hospital Kerry we recognised that falls were the highest reported patient safety incident. In an effort to enhance patient safety, the Falls Committee undertook a series of PDSA quality improvement cycles.

PDSA Cycle 1

Plan

- Evidence reviewed and discussed by committee.
- Review of falls incident data to include Serious Reportable Events.
- Plan to update policy and implement hospital wide.

Do

- Evidence used to inform update of policy.
- Three algorithms developed to clearly communicate to staff - assessment, strategies and management of inpatient falls.
- Streamlining of referral to Health and Social Care Professionals (HSCP) to ensure prompt review.
- Patient information booklet developed.
- Stakeholder engagement undertaken.
- Implementation completed.

Study

Review recognised identifying and communicating falls risk was not enough. The committee was asked to review an audit undertaken on mobility which revealed there was no structured communication between staff regarding a patient's mobility status or goals. A risk adverse approach to mobility was often taken which could paradoxically increase a patient's risk of falls. A succinct joint approach to patient mobility while in hospital was required. It further identified delays between falls risk identification and referral to HSCP's.

Act

The policy was updated to reflect the additional data from the Mobility audit to ensure mobility goals were prioritised as they were identified as a key falls prevention strategy. Nursing staff were reminded that they could directly refer patients at risk of falls to HSCPs. An algorithm was developed to educate on the referral process.

Members of the University Hospital Kerry team involved

PDSA Cycle 2

Plan

- Committee to update the policy to ensure an enhanced focus on mobility.
- Further education to be provided.
- Prioritising knowledge of updated policy at the Nursing Quality and Audit committee.
- Highlight the policy and associated metrics on ward Quality Boards.

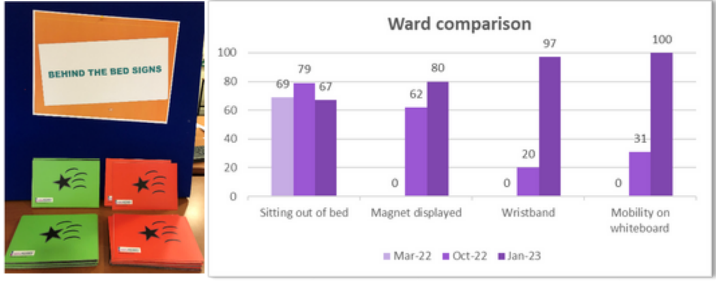
Do

The policy was renamed the Mobility, Falls Prevention and Management Policy 2022 and the following changes were made.

- The patient's mobility status on admission is written on the whiteboards in collaboration with the patient and the physiotherapist, including the display of magnet symbols.
- Patients have become active participants in their mobility goals.
- All staff are aware of the mobility status of the patient and can support them to stay active while in hospital.
- Metrics and policy highlighted on ward Quality Boards Study.

Study

A review of audit data between October 2022 and January 2023 below shows continuing improvement.



Act

With the support of Friends of UHK a prize for the ward that showed excellence in implementing the updated policy was awarded. Education continued. Quality boards were used to relay information specific to compliance with the policy. A re-audit in January 2023 showed significant improvements.

Where can you find out more?

To find out more about this work, please email: Amanda.Brolly@hse.ie.

Lead NCHDs recognised for contribution to quality

Did you know that each year there are National Lead NCHD Quality Improvement Awards which recognise quality improvement excellence? The top three Lead NCHDs projects from 2021-2022 were presented by (in no particular order):

- Dr Max Waters, cardiology SpR and Lead NCHD in University Hospital Kerry presented his project 'Educational Improvement at University Hospital Kerry'.
- Dr Shiraz Siddiq Ali, medical SHO and Lead NCHD in South Tipperary University Hospital presented 'Effects of Simulation teaching'.
- Dr Dómhnall O'Connor, Lead NCHD in Midlands Regional Hospital Tullamore presented 'The Net Promoter Score: An objective metric for NCHD satisfaction in post'.

You can read more in the National Lead NCHD Newsletter from Dr. Jennifer Finnegan, Lead NCHD, NDTP Fellow 2022 - 2023.

What is a PDSA Cycle?

Helpful tips

The Model for Improvement starts with three questions

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

The PDSA Cycle is the next step in the process - testing your change. It includes four phases: plan, do, study, and act.

To find out more and to access this and other tools, you might enjoy the Quality Improvement Toolkit. You can also learn more quality improvement terms.

PATIENT SAFETY TOGETHER

Latest updates

Patient Safety Together (PST) is a freely available on-line platform that provides a reliable and easily accessible way to share patient safety learning within Irish healthcare. It also supports the implementation of the HSE Patient Safety Strategy, 2019- 2024. The National Quality and Patient Safety Directorate (NQPSD) launched this exciting new resource on the 17th January 2023.

Over 16 areas across our health services were involved in co-developing PST over a three year period. Dr. Orla Healy, National Director, NQPSD and Lorraine Schwanberg, Assistant National Director, NQPSD highlighted the dedication and collaboration of teams in building this important new platform.

In the article below, you'll learn a little about the features of PST which includes patient safety alerts, supplements, stories and the Patient Safety Community. Our Patient Safety Together journey starts now!

Maureen Flynn, Flavien Plouzennec, Ulla Devitt, Noemi Palacios

What does Patient Safety Together do?

Patient Safety Together is a platform to share up-to-date patient safety information to help improve our health service for everyone, including healthcare workers, service users and clients.

What are the features of Patient Safety Together?

There are four key features of PST including:

1. HSE National Patient Safety Alerts: Patient Safety Alerts are high-priority communications issued in relation to critical patient safety issues for action.
2. Patient Safety Supplements: Patient safety supplements share relevant quality and patient safety information for learning purposes and to raise awareness.
3. Patient Safety Stories: Patient safety stories give voice to the experience of patients, service users and staff who have been involved in, or impacted by patient safety issues.
4. Patient Safety Community: PST is building a national community for staff working in quality and patient safety in HSE / HSE-funded services to offer peer support and collaboration. Participation is voluntary and there is no obligation on members to produce anything. The Patient Safety Community is led by members who will inform and guide its direction.

First meeting of Patient Safety Community

After the successful launch of Patient Safety Together: learning, sharing and improving on 17th January 2023, the first gathering of the Patient Safety Community was held on 20th February 2023. The gathering brought together staff working in quality and patient safety in the HSE and HSE-funded agencies.

What is the goal of the Patient Safety Community?

The goal of this Patient Safety Community is to create a supportive network for all staff working in quality and patient safety in Ireland. Colleagues can share their experiences and knowledge, and learn from each other on quality improvement and patient safety related issues.

How will the community do this?

The community will do this via virtual sessions, in-person gatherings and an online platform hosted on the Q Community. Through this interactive community, members can connect with each other, share learning and support one another. To ensure its value and ongoing success, the community will be informed and guided by its members.

We collected feedback from members following the initial meeting to inform and guide the direction of the group including how we will interact, how the sessions will run and to identify potential patient safety issues and topics of interest for the community to discuss and explore.

So what are people saying so far?

"Great initiative, delighted to be part of!"
"Fairly new to my role, it's a great idea."
"Welcome the opportunity to network with like-minded people."

Patient Safety Community
What do you need to know?

- A national community for staff working in QPS in HSE / HSE-funded services.
- Established by the National Quality and Patient Safety Directorate as part of Patient Safety Together.
- Led by members who inform and guide its direction.

How can you join the Patient Safety Community?
Contact patientsafetytogether@hse.ie to learn more.

Latest Patient Safety Supplement: The Risk of Smoking in our Acute Hospitals

The latest Patient Safety Supplement from PST is now available! It aims to raise awareness of the significant risks of smoking and vaping in a healthcare setting and support staff to explain these risks to patients to enable their safety and that of other patients and staff. The Supplement highlights four smoking related incidents:

1. Smoking near oxygen,
2. Aggression towards staff,
3. Smoking after using alcohol gel, and
4. Other ongoing challenges, including falls.

We acknowledge and support all reasonable measures to ensure healthcare facilities and environments are safe for patients, carers and staff. When individual personal choices create challenges to personal safety and the safety of others it is within the duty of service providers to do all they can to address those challenges and reduce risk."

Patients for Patient Safety Ireland

Olivia Wall on why she joined the Q Community?

What is the Q Community?

The Q Community is a connected community working together to improve health and care quality across the UK and Ireland. Q's mission is to foster continuous and sustainable improvement in health and care. Learn more on the Q Community website.

Why did you join Q?

I joined the Q Community in 2020. It was advertised as a way to link people together in Ireland and the UK with an interest in quality and patient safety. A myriad of benefits were linked with membership and it was free, so it was an easy decision!

How has it improved your work?

Q has helped me, as it has opened the door to an online network of improvers who generously share ideas and resources.

It is an ideal avenue to be able to link with others and the frequent national online catch ups are a great way of hearing what is going on nationally. There is always some nugget of information to be gleaned from joining a call - for example: a book recommendation, a journal article, a method of improvement, hearing about practical experience of using a tool from the QI toolkit, the use of a Liberating Structure to enhance stakeholder engagement etc.

Another benefit of membership is the ability to seek practical advice in relation to the many quality improvement queries that one may have.

What do you think Q can offer those working in quality improvement and patient safety?

Q membership offers access to free online webinars and an instant community of improvers.

It offers a place to pose a question, seek advice and share experiences with others. I'd strongly encourage anyone with an interest in quality improvement and patient safety to consider joining up.

How can you join Q-Community?

Good news! The NQPSD covers all fees in joining Q.
To apply, contact Roisin.Egenton@hse.ie from our QPS Improvement Team.

Quality and Patient Safety Data for Decision Making Toolkit

A new resource to support you using data to improve oversight of quality and safety

In conversation with Dr. Gemma Moore, Qualitative Evaluation and Research Officer

Governance of quality and safety can be very challenging in large complex healthcare organisations like the HSE. Including a quality agenda item at meetings can support a board, committee or leadership team to improve oversight and accountability of quality and patient safety.

The QPS Intelligence team have developed a QPS "Data for Decision Making Toolkit" to assist committees, boards and leadership teams interested in developing their own quality agenda items.

The toolkit is based on the team's experiences of co-designing quality agenda items with the Mater Misericordiae University Hospital Hospital Board, Children's Health Ireland at Temple Street Board, the HSE Directorate and the HSE Board's Safety and Quality Committee.

Two complementary quality agenda items were co-designed during these projects providing a quantitative and qualitative picture of quality.

- A 'Quality Profile' is where a selected critical few indicators across domains of quality are presented. Statistical Process Control (SPC) methodology are used to analyse and display variation over time and across a system, and to differentiate between expected and unexpected variation.
- 'People's Experience of Quality' is where both positive and negative patient, service-user, family and staff experiences are shared at meetings via 'stories', videos, research findings or people attending meetings to describe their experience face-to-face.

Why is this important?

Regularly discussing quality and safety through a quality agenda item will help boards, committees or leadership teams to:

- Evolve their approach to overseeing and improving quality at organisational or service level.
- Develop a culture of assurance in their organisation or service.
- Establish whether care in their organisation or service is safe or unsafe.
- Help identify patient safety issues and system failures.
- Take appropriate actions to reduce the risk to patients and staff.
- Understand the lived experiences of those who use and work in their organisation or service.

What is this toolkit?

The QPS Data for Decision Making Toolkit contains four parts

Part	Description
Part 1: Planning and testing a quality agenda item	This section contains tools and resources useful when establishing your quality agenda project. The tools facilitate and support a QI approach to your project.
Part 2: Producing a Quality Profile	This section contains tools and resources for designing a Quality Profile and for producing and interpreting statistical process control and run charts.
Part 3: Producing People's Experiences of Quality	This section contains guidance on developing patient, service user, family and staff 'stories' or experiences to share at committee, board or leadership team meetings.
Part 4: Evaluation and Feedback	This section provides useful tools and resources to help you capture feedback from committee, board and leadership members and to evaluate your project.

Where can I learn more?

Ask

Ask your board or management team if they include a 'Quality Profile' or a 'People's Experience of Quality' on their regular agenda.

Listen

Listen to Episode 4 of our All-Ireland podcast, Walk and Talk Improvement, on the use of data for assurance and improvement. Dr. Gemma Moore and Grainne Cosgrove chat with Professor Deirdre Madden about how combining different types of data presented in the right way can help boards and committees in leading and overseeing healthcare organisations in QPS.

You'll also hear from patient partner Gemma Willis, and Keith Synnott and Damian McGovern from the Trauma Services team about the importance and value of board and committee members engaging with people's lived experiences of using and working in healthcare. The series is available on Spotify, Amazon Music Prime, YouTube and Google Podcasts.

Access

Access the QPS Data for Decision Making Toolkit on our website.

Acknowledgements

Sincere thanks to members of the Mater Hospital Board, Children's Health Ireland at Temple Street Board, the HSE Directorate and the HSE Board Safety and Quality Committee who through co-design have helped refine our approach and help identify the key steps to develop a Quality Agenda Item. We would also like to acknowledge our colleagues across HSE National Quality and Patient Safety Directorate who developed a number of tools contained in the toolkit.

Open Disclosure "The Right Thing to Do"

What training is available for Open Disclosure?

Did you know Open Disclosure training is mandatory for all staff working in HSE and in HSE-funded services with refresher training required every three years?

The training is free and is available through the HSELand e-learning Module 1 “Communicating Effectively through Open Disclosure”.

Staff who may be involved in formal open disclosure meetings, such as senior managers, senior nursing staff, midwifery and health and social care professionals, medical staff, QPS staff and staff fulfilling the role of the Designated Person must also complete:

- E-learning Module 2 “Open Disclosure: Applying Principles to Practice”, and
- Face to Face Module 3 Skills Workshop (3 hours) on the management of the open disclosure process.

Where can I learn more?

The National Open Disclosure Office facilitates monthly webinars on Open Disclosure related topics.

You can join upcoming webinars or watch previous webinars on our website.

We are delighted to welcome a variety of HSE internal and external guest presenters to these educational events. All staff are welcome to attend the Open Disclosure Webinars.

Date for your diary

Open Disclosure week 2023
2nd - 8th October 2023

The week focuses on a number of themes pertaining to Open Disclosure including:
patient perspective | documentation
approaches to implementation of the HSE Policy |
training | staff support.

Email opendisclosure.office@hse.ie for further information and resource pack

Pictured below are students from Dalkey Nursing Unit at Open Disclosure Week in November 2022.

What is a Confidential Recipient?

The Confidential Recipient is a person who acts as a voice and advocate for vulnerable people with a disability and for older people who wish to report a concern and / or complaint. They are completely independent of the HSE.

Who is the current Confidential Recipient and what is her role?

The current Confidential Recipient is Gráinne Cunningham. In her role, Gráinne has the authority to review concerns and complaints reported to her. She will

- advise and assist individuals on the proper course of action to take,
- assist with the referral process to the relevant HSE Chief Officer to ensure review of reported concerns and complaints, and
- confirm that the reported concern and / or complaint is responded to by the HSE Chief Officer in line with the agreed fifteen working day response timeframe.

How can I contact the Confidential Recipient?

Confidential Recipient
grainne.cunningham@crhealth.ie | 087 665 7269

Office Administrator
etta.shanahan@crhealth.ie | 087 1880523

General Queries: cr.office@crhealth.ie

Building a Just Culture in Healthcare: A HSE Dialogue

The National Quality and Patient Safety Directorate in conjunction with the Centre for Innovative Human Systems, Trinity College, Dublin is organising a full day learning event, centred around building a Just Culture in patient safety in the HSE.

Keynote speakers will be Amanda Oates and Joe Rafferty, Mersey Care, NHS Foundation Trust, co-authors with Sydney Dekker of Restorative Just Culture in Practice: Implementation and Evaluation.

With the support from patient partners and our CEO, it is intended to open up a dialogue amongst senior HSE managers and staff with a role in the implementation of a just culture and psychological safety in their workplace.

Registration details to follow shortly.

Save the Date
Building a Just Culture in Healthcare: a HSE Dialogue
23rd May 2023 | 09.30 - 16.30
Croke Park Conference Centre, Dublin

Latest from the QPS Prospectus

QPS TalkTime participants venture into breakout rooms

On 7th March 2023, QPS TalkTime presented a unique episode focused on the Prospectus of Quality & Patient Safety Education & Learning Programmes.

Hosted by Dr. John Fitzsimons, Juanita Guidera, Dr. Mary Browne and Veronica Hanlon, this QPS TalkTime featured leads from each of the programmes listed in the Prospectus. Following an overview of the prospectus, participants were invited to join two of 12 breakout rooms to explore subjects of interest or to stay in the main session. This provided the participants with the opportunity to not only learn more about how to use the Prospectus but ask programme leads any questions they had.

This approach proved to be very popular with participants. A huge thanks to all leads for their support, our QPS TalkTime facilitators and all our attendees.

Missed it? Catch-up on the recording of the "Expand your Knowledge" (The recording is of the main room as the technology does not yet support recording breakout rooms.)

@QPSTalkTime is a free fortnightly webinar with local, national and international speakers. It is open to everyone. You can register for upcoming sessions or watch back old ones on our website.

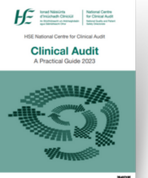
Pictured right are some of our panellists and hosts from the @QPSTalkTime session, (from top left) Angela Tysall, Catherine Hogan, Dr. Mary Browne, Veronica Hanlon, Dr. John Fitzsimons, Gemma Moore, Barbara Slevin, Bridget McDaid, Carol Clarke, Corrine O'Hare, Elaine Ahern, Elaine Birkett, Helen Clark, Juanita Guidera, Karen Reynolds, Margaret Codd, Mary Friel, Nicola Fay, Patricia Gibbons and Dr. Samantha Hughes.

The 2023 Prospectus of Quality & Patient Safety Education & Learning Programmes provides information about quality improvement and patient safety educational resources across the HSE. The aim of this prospectus is to help you plan your learning for the year ahead.

Access the Prospectus for information on how you can develop knowledge and skills in:

- Quality Improvement
- Incident Management
- Open Disclosure
- Clinical Audit
- Human Factors
- Schwartz Rounds
- Liberating Structures
- Data for Decision Making
- Complaints, Governance and Learning
- Governance and Risk
- Safeguarding
- Antimicrobial Resistance and Control (AMRIC)
- Change and Innovation
- Library Services

Access the prospectus on our website.



National Centre for Clinical Audit publishes Clinical Audit A Practical Guide 2023

The National Centre for Clinical Audit (NCCA) has just published the HSE National Centre for Clinical Audit - Clinical Audit A Practical Guide 2023. This is a useful guide for anyone interested in clinical audit.

What is the National Centre for Clinical Audit (NCCA)?

NCCA is working to ensure a strategic integrated approach to all Clinical Audit activity and developments. Established in April 2022 following publication of the HSE National Review of Clinical Audit Report (2019), it is primarily responsible for implementing the report's recommendations under five key pillars.

The NCCA is building the capacity and capability of HSE staff, services and stakeholders to standardise and promote the implementation of an agreed programme of work for National Clinical Audit. The team are part of the National Quality and Patient Safety Directorate and collaborate with HSE Services, clinical audit services that are funded by the HSE, external stakeholders and Patient Representative Groups. A wide range of National clinical audits are commissioned and managed on behalf of the HSE by our clinical audit national service providers.

What can you do to learn more?

Learn more in our HSE National Centre for Clinical Audit - Clinical Audit A Practical Guide 2023

The NCCA also provides a Clinical Audit Education and Training Programme. It covers a range of virtual and in person training options including Fundamentals in Clinical Audit, Advanced Clinical Audit and the Train the Trainer course. See the Prospectus of Quality & Patient Safety Education & Learning Programmes for more information / bookings are available on Eventbrite.ie.

TIP: The terminology around clinical audit can be confusing at times. To help with this, we have put together a Nomenclature - Glossary of Terms for Clinical Audit.

More information? Connect via ncca@hse.ie and on twitter @hsencca

Five key pillars

1. National Governance for Clinical Audit
2. Local Governance for Clinical Audit
3. Education and Training for Clinical Audit
4. Education and Training Resources for Clinical Audit
5. Legislative Changes affecting Clinical Audit

Clinical audit national service providers

- **National Office of Clinical Audit (NOCA)**
- **Royal College of Physicians of Ireland (RCPI)**
- **National Perinatal Epidemiology Centre (NPEC, UCC)**
- **National Clinical Strategy and Programmes Division (NCSPD)**
- **Out of Hospital Cardiac Arrest Register (OHCAR, NUI, Galway)**

HSE Human Factors programme

Human Factors is not new. Since 2015 the need for targeted Human Factors training and education has been highlighted in the National Clinical Guidelines in Ireland, but until now, no specific e-learning programme was available in the HSE.

Who developed the programme?

This introductory 20 minute, self-directed, e-learning programme, was developed by the NQPSD and Human Factors Facilitators Group, including patient partners. It introduces Human Factors as a way of thinking about safety in everyday work.

What is the aim of this programme?

This programme is offered as the first step in a learning pathway that seeks to build the learner's knowledge and skills relating to Human Factors. It aims to entice participants to want to know more about why and how human factors can improve the performance and well-being of individuals and teams, and influence safety in the healthcare system.

Who can do this course and where?

Staff and patient partners across all areas of health service can do this programme. You can access the programme from HSELand. The course is free.

Where can I get more information?

For more information about this and other Human Factors Programme work, contact: margaret.codd@hse.ie.

Spotlight on HIQA's online learning courses

HIQA has developed online learning courses to support staff working in health and social care services to understand and implement national standards. There are currently four courses available, in the areas of:

- Information management - data quality
- Infection, prevention and control
- Adult safeguarding
- Human rights-based approach to care.

An additional course on the Fundamentals of Advocacy will be launched in the coming months. To date, these courses have been accessed over 160,000 times and learner feedback has been very positive. The online courses are available on HSELanD, where certificates of completion are provided.

Learn more about HIQA's work.

Engaging staff in Quality and Patient Safety

"There is profound wisdom in the room when people ask a question, create space to hear what may be said, and listen. Conversations change lives."

The evidence for quality and patient safety increasingly identifies engagement as a key indicator of organisational performance. While engagement is sometimes seen as an added extra, the most effective leaders develop their competency for engagement as part of their way of working.

In the National Quality and Patient Safety Directorate's work to support staff in the implementation of the Patient Safety Strategy 2019 - 2024, Commitment 2: Empowering and Engaging Staff to Improve Patient Safety, we recently hosted "An introduction to engagement techniques for quality and patient safety #liberating structures" in Dublin and Galway. All of the offered programmes were over subscribed!

The programme introduced several microstructures called liberating structures. Whether you're exploring healthcare challenges or involved in strategic planning for a service, these are powerful tools that encourage meaningful conversation and action. During our programmes, using the microstructures, we explored healthcare challenges like patient engagement, integrated care planning to improve hospital discharge, implementing quality and patient safety programmes, addressing common causes of harm and improving communication.

Key to doing this work well is self awareness, insight into the organisational culture, and knowledge of the enablers and barriers to engagement. It was helpful for participants to begin to consider what that looks like in their current roles. Thanks again to all who participated.

Where can you learn more?

Liberating structures were developed by Keith McCandless and Henri Lipmanowicz and have a foundation in complexity science. You can learn more from the website or by downloading the app Liberating Structures.

Pictured below are staff and patient partners who participated in "An introduction to engagement techniques for quality and patient safety #liberating structures" in Dublin and Galway on the 27th February and 20th March 2023 respectively.

Upcoming events

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

QPS TalkTime

Join our lunch time one hour webinar series fortnightly from 13.00 - 14.00 with local, national and international speakers. @QPSTalkTime is open to everyone interested in improving quality and patient safety across our healthcare services. Connect individually or with a group to help build your own local QPS networks. Upcoming topics include safer surgeries… steps to reduce risk of harm, patient partnerships, the power of storytelling in quality and patient safety, safeguarding and psychological safety for leaders.

You can register for upcoming sessions or watch the catalogue of recordings.

Dates for the diary: 18 April | 02 May | 16 May | 30 May | 13 June | 27 June

Second bi-annual NQPSD Symposium (by invitation)

NQPSD Symposiums will be held twice a year to provide a space for sharing and creating a unified approach to delivering the HSE Quality and Patient Safety agenda. Working in partnership with HSE operations, patient partners and other internal and external partners, this forum will provide an opportunity to strengthen working relationships, generate consensus and alignment on Quality and Patient Safety developments.

Date for the diary: 25 April

Open Disclosure webinars

Monthly webinars from 11:00- 12:30 on Open Disclosure related topics open to all staff and CPD accredited by RCPI and NMBI (for those who attend the live event).

You can find links for upcoming sessions or watch the catalogue of recordings on our website.

Dates for the diary: 17 May | 14 June | 12 July

Building a Just Culture in Healthcare: A HSE Dialogue

Save the Date: 23rd May 2023 | Croke Park Conference Centre, Dublin | 09.30 - 16.30.

Registration details to follow soon.

Thank you for reading our first 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.**

We look forward to hearing from you.

Spotlight on upcoming training

National Centre for Clinical Audit Training

Fundamentals in Clinical Audit Workshop

3 May | 15 May

Train -the-Trainer in Clinical Audit

22 May | 23 May

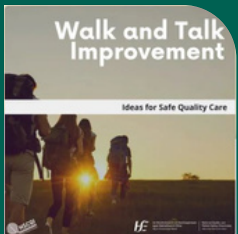
Advanced Clinical Audit Course

12 June
11 | 12 | 21 September
04 | 05 October

Coaching for Improvement

12 April | 23 October

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



Walk and Talk Improvement - Latest Episodes

All-Ireland podcast that aims to improve patient care by capturing 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.

Thank you

Thank you for taking the time to read Quality and Patient Safety Matters #AllThingsQuality. Please feel free to share it with friends and colleagues who may enjoy it.

We would not be an improvement team if we did not want to continually improve, so please help us! We invite you to click on the link below to share your feedback about the newsletter in a short survey.

We thank you in advance!