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1. Introduction

1.1 Background and objectives

The HSE is committed to the provision of safe, high quality health services through the achievement of excellence in clinical governance\(^1,2\). Raising and maintaining the quality and safety of care requires sustained commitment to continuous improvement from everyone involved in the health and personal social care system. This should lead to achievement of best possible health and personal social care outcomes for patients and service users within the resources available to the HSE.

The HSE has issued a *Quality and Risk Standard* that sets the criteria for implementation of an integrated quality, safety and risk management system across the HSE. The aim of the standard is to provide a common set of requirements that will apply across all service providers to ensure that health, personal and social services are both safe and of an acceptable quality.

This document describes the overarching strategy for implementing the HSE *Quality and Risk Standard* in all services managed or funded by the HSE. The objectives of the strategy are to:

1. ensure that there is an appropriate framework for quality, safety and risk management\(^3\) in place across all HSE service providers in health, personal social care to support and drive improvements in the provision of safe, effective, high quality services;

2. drive core programmes of work in quality, safety and risk management, including: clinical effectiveness; service user and community involvement; risk management and patient safety; continuous professional development; and service improvement; and

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\(^1\) Clinical governance is a concept created in the NHS in England and defined as “A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” The framework described in this document, properly implemented, exceeds minimum clinical governance requirements and is expected to result in excellence in clinical governance. The NHS in Scotland defines clinical governance as “corporate accountability for clinical performance.”

\(^2\) The term ‘clinical’ should be interpreted as relating to involvement of all types of care professionals working in the health, personal and social care field.

\(^3\) The terms ‘quality, safety and risk management’ and ‘quality and risk management’ are, for the purposes of this document, regarded as synonymous.
3. ensure that appropriate accountability and oversight arrangements are in place to monitor quality, safety and risk management performance and to support the provision of assurances to senior management, the CEO of the HSE and to the HSE Board.

It is recognised that there are many good approaches to improving quality, safety and risk management already being pursued by service providers. It is not, therefore, the intention of this document to be highly prescriptive. Rather, key requirements are set out and ‘check questions’ are provided for consideration by service managers and clinicians in an attempt to identify any areas for improvement. An Electronic Self-Assessment Tool is available that allows service providers to ‘score’ themselves in relation to the check questions. And additional guidance on meeting the requirements of the check questions is provided in the Companion Guide associated with this document.

1.2 Related policy and regulatory considerations

The primacy of patient safety, quality of care and management of risk generally in the planning, provision and review of health, personal and social care services is increasingly being recognised.

The Health Strategy Quality and Fairness: A Health System for You (2001) set out an ambitious quality agenda for the Irish health service, with four national goals: better health for everyone; fair access; responsive and appropriate care delivery; and high performance. The strategy has a strong focus on safe and effective care.

The HSE Transformation Programme (2007) aims to achieve a health service where “Everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide.” This will require a fundamental change in the way in which services are delivered, putting patients at the heart of service planning and delivery and developing systems to ensure that we do the right thing, every time for each patient.

The regulatory environment in which the HSE operates is complex and evolving. The Mental Health Commission, for example, has produced a quality framework for mental health services, and with the establishment of the Health Information and Quality Authority (HIQA) it is anticipated that some form of wider organisational quality assurance

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4 Refer to the Companion Guide to the Framework Document.
5 See www.mhcirl.ie
A key existing regulatory requirement is the *Safety, Health and Welfare at Work Act 2005*, which requires employers, including the HSE, to ensure, so far as is reasonably practicable, that their activities are managed and conducted in such a way as to ensure the safety, health and welfare of staff, patients, visitors and others. The HSE’s *Corporate Safety Statement* demonstrates compliance with the Act and describes the HSE’s approach to safety management.

In July 2008, the *Commission on Patient Safety and Quality Assurance*, established in 2007 by the Minister for Health and Children, reported on building a culture of patient safety in Ireland. Of the 134 recommendations made by the Commission, 70 are directly relevant to the HSE and should be met through proper implementation of the quality, safety and risk management framework described in this document.
2. Framework for integrated quality, safety and risk management

2.1 Introduction

Figure 1 illustrates the framework for integrated quality, safety and risk management, which is based on the HSE Quality and Risk Standard. The framework was developed by HSE staff in the National Hospitals Office (NHO) and Primary, Community and Continuing Care (PCCC) Directorates. During summer 2008, a ‘pilot’ of the framework was carried out by a UK healthcare consultant and involved three hospitals and three local health offices. The principal purpose of the pilot was to provide an independent assessment of the efficacy of the framework and to develop a Companion Guide to assist service providers with self-assessment against the framework.

Figure 1 – Framework for integrated quality, safety and risk management. The term ‘Patient/Service User’ should also be interpreted as ‘client.’
There are three key components to the framework:

1. Essential underpinning requirements
2. Core processes and programmes that lead to good outcomes
3. Performance indicators that demonstrate improvements in quality, safety and risk management and link, where possible, to good outcomes for patients etc.

Together, these components form the basis for a self-assessment by service providers of the extent to which an integrated quality, safety and risk management system is in place that conforms to the framework and meets the requirements of the overarching HSE Quality and Risk Standard. Each component is elaborated in more detail in subsequent sections in this document.

A total of 69 ‘check questions’ relating to key aspects of the framework have been developed. Managers and clinicians can, with reference to this document, the supporting Companion Guide and the Electronic Self Assessment Tool, assess the extent to which an integrated framework for quality, safety and risk management is in place within their hospital or service. On completion of the self-assessment process, where improvements are required then an action plan should be developed. Regular monitoring and review of action plans will ensure that actions are being implemented, leading to better outcomes for patients and others.

### 2.2 Essential underpinning requirements

The following are the essential underpinning requirements that service providers must have in place in order to drive safe and effective care. Many of these requirements will ensure that effective leadership and management is in place to drive forward the quality, safety and risk management agenda.

#### 2.2.1 Communication and consultation with key stakeholders

Effective communication and consultation structures and strategies should be in place with key stakeholders within and outside the organisation, including staff and patients. A stakeholder analysis should be conducted to ensure firstly that all appropriate stakeholders have been identified and, secondly, that appropriate mechanisms have been

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7 The term ‘organisation’ is used here to describe a hospital or other health, personal and social care service provider.
defined for communicating and consulting with the various stakeholders or stakeholder
groups.

2.2.2 Clear accountability arrangements

Appropriate **accountability** arrangements for quality, safety and risk management should be in place at all levels from front line staff up to the organisation’s most senior accountable manager or, in the case of voluntary hospitals, governing body. Individual responsibilities will typically be set out in job descriptions. Accountability arrangements should also be set down for committees and/or groups involved in quality, safety and risk management. These should include clear terms of reference and robust reporting arrangements. Committee structures should, where relevant, build into an integrated framework that provides for coordination of all quality, safety and risk activities and information. Interdependent groups that must work together effectively and share resources should be linked by hierarchy, information systems, common membership (as appropriate), meeting schedules, etc.

It is likely that organisations will have, or will establish a committee or group to oversee quality, safety and risk management performance and to report periodically to local senior management. Where relevant, consideration should be given to the need for such a committee to reflect the multi-professional membership required to achieve comprehensive quality, safety and risk management across all of the service provider’s operations.

2.2.3 Adequate capacity and capability

The organisation should have the **capacity** and overall **capability** to implement and monitor effective quality, safety and risk management systems. Capacity and capability implies qualified people, adequate physical and financial resources and access to specialist expertise where necessary. Managers at all levels should fulfil their responsibility by demonstrating commitment to the management of quality, safety and risk management. Budget development and financial resources should be aligned with the organisation’s quality and safety goals to ensure ongoing review and consideration of such priorities when developing service and other business plans. And, all staff should be provided with adequate quality, safety and risk management information, instruction and training appropriate to their role.
2.2.4 Standardised policies, procedures, protocols and guidelines (PPPGs), including a standardised document control process

The organisation should have a system in place to facilitate all services in the development of standardised policies, procedures, protocols and guidelines (PPPGs – however named). These guidelines should be based on best available evidence and should be governed by a formal document control process that includes processes to support the ongoing review and change of PPPGs. Staff should be provided with support and guidance on the sourcing, appraising, and implementation of evidence based practice and on implementing any resulting changes in practice. Where new services are being established, the development of policies, procedures, protocols and guidelines should be considered at the time of commissioning.

2.2.5 Robust monitoring, reporting and review arrangements

Senior managers should ensure adequate monitoring and review of the systems in place for quality, safety and risk management. All aspects of the framework described in this document should be regularly monitored and reviewed in order that management can learn from any weaknesses in the systems and make improvements where necessary. This should include subjecting key performance indicators (KPIs) relating to outcomes to regular review (e.g. monthly or quarterly) to establish trends and to pick up anomalies that require further investigation. The results of periodic independent audits should also be reviewed to ensure that action plans are developed and implemented to rectify any system weaknesses (see section 2.2.6). There is a need to develop suitable KPIs for quality, safety and risk management and to report on selected KPIs (see section 2.4.1, together with the Companion Guide).

2.2.6 Assurance arrangements

Senior managers should ensure that they obtain sufficient assurance on the effectiveness of the systems in place for quality, safety and risk management to form part of their monitoring and review process. Assurances can come from a variety of sources either within or outside the HSE. The most objective assurances are derived from independent reviewers which include internal audit, the Mental Health Commission, HIQA, the Health and Safety Authority, the C&AG and external accreditation bodies. The national decontamination, hygiene and healthcare records audits are examples of important external sources of assurance. These are supplemented from non-independent sources
which include clinical audit, internal management representations, performance management and self assessment reports.

### 2.2.7 Check questions

The table below contains ‘check questions’ that can be utilised by organisations to gain an understanding of their strengths and areas for improvement in relation to implementation of the underpinning requirements outlined above. The responses to these questions can be either ‘yes’, ‘no’, ‘partial’, ‘not applicable’ or ‘don’t know’. The ‘partial’ responses are categorised as ‘low’, ‘moderate’ or ‘high’. Where a no or partial response is provided, an action plan or ‘quality improvement plan’ (QIP) should be developed to implement any requirements. Where the question number box is shaded, this denotes that the response to the question may need to be made following the gathering and aggregation of appropriate information from a number of departments, service areas, etc. Further information on the assessment process is provided in the Companion Guide and also with the Electronic Self-Assessment Tool.

<table>
<thead>
<tr>
<th>Essential underpinning requirements: Check questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Communication and consultation with key stakeholders</strong></td>
</tr>
<tr>
<td>1. Has a ‘stakeholder analysis’ been carried out to identify all internal and external stakeholders relating to quality, safety and risk management?</td>
</tr>
<tr>
<td>2. Are arrangements in place to ensure that the ‘stakeholder analysis’ is maintained up-to-date?</td>
</tr>
<tr>
<td>3. Is there effective communication and consultation with internal stakeholders in relation to the purpose, objectives and working arrangements for quality, safety and risk management?</td>
</tr>
<tr>
<td>4. Are internal and, where appropriate, external stakeholders kept fully informed on progress to achieve quality, safety and risk management objectives?</td>
</tr>
<tr>
<td>5. Is there effective communication and consultation with external stakeholders in relation to quality, safety and risk management?</td>
</tr>
</tbody>
</table>
### B. Clear accountability arrangements

1. Are clearly documented accountability arrangements in place to support the organisation’s most senior accountable manager to discharge his/her responsibility for quality, safety and risk management?

2. Do the documented accountability arrangements ensure that the organisation’s most senior accountable manager is fully informed in relation to key areas of quality, safety and risk performance?

3. Are the roles and responsibilities played by any committees or groups described clearly within the accountability arrangements?

4. Do committee structures and reporting arrangements provide for coordination and integration of quality, safety and risk activities and priorities?

### C. Adequate capacity and capability

1. Do managers at all levels fulfil their responsibility by demonstrating commitment to the management of quality, safety and risk?

2. Do service planning and other business planning arrangements take into account the quality, safety and risk management goals and priorities of the service provider when developing budgets and other financial strategies?

3. Is a defined percentage or allocation of the organisation’s annual budget committed to achieving defined quality, safety and risk management goals?

4. Is there access to appropriate resources to implement effective quality, safety and risk management systems, e.g. qualified people, physical and financial resources, access to specialist expertise, etc.?

5. Are all staff provided with adequate quality, safety and risk management information, instruction and training appropriate to their role?
### D. Standardised policies, procedures, protocols and guidelines

1. Does the organisation operate a standardised document control process for all policies, procedures, protocols and guidelines?

2. Are arrangements in place for training staff in appraising and developing policies, procedures, protocols and guidelines and for identifying evidence-based best practice?

3. Are policies, procedures, protocols and guidelines standardised throughout the organisation and, where appropriate, are they evidence-based?

4. Are arrangements in place to ensure that where new services are being established, the development of policies, procedures, protocols and guidelines is considered at the time of commissioning?

### E. Monitoring and review arrangements

1. Are all aspects of the framework described in this document regularly monitored and reviewed in order that management can learn from any weaknesses in the systems and make improvements where necessary?

2. Are the results of independent and other audits used to inform improvements in quality, safety and risk management systems?

3. Are key performance indicators reviewed regularly to identify and correct anomalies and to drive continuous improvement in quality, safety and risk management?

### F. Assurance arrangements

1. Does senior management receive sufficient assurance on the systems in place for quality, safety and risk management?

2. Do the assurances received by senior management form an integral part of their ongoing monitoring and review processes?
2.3 Core processes and programmes

Organisations should, where appropriate, have in place the following core processes and programmes.

2.3.1 Clinical effectiveness and audit

The term ‘clinical effectiveness’ is used in this document to encompass clinical audit and evidence-based practice (refer to Companion Guide).

A structured programme, or programmes, should be in place to systematically monitor and improve the quality of clinical care provided across all services. This should include, systems to monitor clinical effectiveness activity (including clinical audit); mechanisms to assess and implement relevant clinical guidelines; systems to disseminate relevant information; and use of supporting information systems.

The processes and outcomes of care should be regularly audited and should demonstrate that the delivery of care reflects adopted guidelines and protocols. Audits should be based on agreed selection criteria such as: high risk, cost, or volume; serious concerns arising from adverse events or complaints; new guidelines; local or national priorities; or patient focus. Existing national priorities that should be considered include: cancer; coronary heart disease; stroke; and diabetes.

Where appropriate, and whenever possible, clinical effectiveness activities should be patient centred. That is, they should take into account the whole patient journey. This requires multi-professional working and working across organisational boundaries.

Clinical effectiveness activities have a significant cost implication in terms of the resources required to support projects and the opportunity cost of professionals examining and assessing their practice. These costs need to be justified and organisations should be able to demonstrate that the clinical effectiveness activities that they support result in demonstrable improvements in the standards of care and represent efficient use of resources.

2.3.2 Patient/service user and public/community involvement

Mechanisms should be in place to involve patients/service users and the public/communities in the planning, development, delivery and evaluation of health
services. These mechanisms should be evaluated and the results of this involvement used to improve the manner in which services are configured or delivered. This should include a systematic process to ensure that organisations respond to, and learn from all forms of feedback.

A baseline assessment of service user and community involvement should be conducted in line with the requirements of the HSE/DOHC Strategic Plan for Service User and Community Involvement 2007-2012, and best practice guidance associated with this plan should be taken into account when developing local systems. A range of mechanisms will be developed to support the implementation of the HSE/DOHC strategic plan and these will be available to support local managers, staff and service users when developing their own programmes.

Service user and community involvement should be facilitated at all levels of the organisation, including individual care episodes, information development, service planning, staff and service user education and quality review and improvement.

2.3.3 Risk management and patient safety

2.3.3.1 The risk management process

Risks of all kinds should be systematically identified, assessed and managed in order of priority, in accordance with Australian/New Zealand Standard AS/NZS 4360:2004 ‘Risk management’. “Risk of all kinds” means that risks need to be managed ‘across the board’, including risks to the safety and quality of patient care; occupational health, safety and welfare risks; environmental and fire safety risks; risks to ‘business continuity’; and so on. The principal vehicle for managing and communicating risk at all levels is the ‘risk register’, which allows a repository of risk information to be maintained. The HSE’s Guidelines on the Process for Managing Risk provides helpful practical guidance on the implementing risk management, including developing and maintaining a risk register, in accordance with AS/NZS 4360:2004.

2.3.3.2 Known high priority risks

Notwithstanding the need to systematically identify, assess and manage risks of all kinds, service providers should be able to demonstrate that they have systems in place to manage known high priority risk issues such as:
− Medication management
− Slips, trips and falls
− Violence and aggression
− Vulnerable adults and children
− Infection control
− Haemovigilance
− Utility contingency
− Medical devices
− Waste management
− Moving and Handling
− Restraint
− Suicide and deliberate self harm
− Patient absconsion
− Management of patient information
− Lone working
− etc.

2.3.3.3 Patient safety

Internationally, patient safety is now recognised as a major concern which requires a specific management focus. An ongoing programme of patient safety improvement should therefore be in operation. All risks to patient safety should be identified, assessed and managed in line with implementing the risk management process set out above.

2.3.3.4 Occupational safety, health and welfare

All staff-related occupational safety, health and welfare risks should be identified, assessed and managed in line with implementing the risk management process set out above. Appropriate systems and processes should be in place to ensure the management of occupational safety, health and welfare. The Health and Safety Authority’s (HSA) Health Services Health and Safety Audit tool should be used to assist with implementing suitable systems. The questions from the HSA tool have been incorporated into a version of the Electronic Self-Assessment Tool that accompanies this framework.

2.3.3.5 Environmental and fire safety

All environmental and fire safety risks should be identified, assessed and managed in line with implementing the risk management process set out above. Appropriate systems and processes should be in place to ensure that environmental and fire risks are minimised through meeting legislative and mandatory requirements.
2.3.3.6 Incidents, complaints and claims recording, analysis and learning

Recording, analysing and learning from all types of incidents, complaints and claims are key components of a successful ‘reactive’ approach to risk management. All incidents, complaints and claims should be properly recorded; reported to management; managed in accordance with an agreed policy; rated according to impact; reviewed where appropriate to determine contributory factors, root causes and any actions required; and should be subjected to periodic aggregate reviews to identify trends and further opportunities for learning, risk reduction and quality improvement.

2.3.4 Staffing and staff management

Systems should be in place to ensure appropriate workforce planning, recruitment, induction, and training and development for staff appropriate to their roles and responsibilities, including compliance with related:

- HSE and DOHC policy and guidance;
- Professional and other codes of practice; and
- Employment legislation.

Robust pre-employment checks should be undertaken in line with national policy including: qualifications of staff to ensure that they are suitably qualified and are registered with the appropriate professional (or occupational) body; relevant Garda clearance checks, health assessment as necessary; and in all cases references should be obtained.

Continuing learning and development programmes aimed at meeting the development needs of staff and the service needs of the provider should be in place and should facilitate professional and regulatory requirements and inform the organisation's training, education and workforce development.

2.3.5 Service improvement

Notwithstanding the core processes and programmes outlined above, organisations should ensure that there is a structured programme in place to support continuous quality improvement across all services. This requires the identification of quality priorities for the organisation; adopting relevant approaches to quality improvement; and utilising appropriate quality tools to secure demonstrable benefits for stakeholders.
Organisations should participate in relevant external quality assurance programmes where available. This will assist them in implementing a comprehensive quality improvement programme incorporating externally recognised standards as well as internally led initiatives.

### 2.3.6 Learning and sharing

It is essential that all service providers develop a learning culture and that effective learning and sharing processes are developed to spread good practice and generally educate/inform others. The pursuit of continual improvement in quality, safety and risk management is crucially dependent on learning from experience and on sharing information good practice for learning purposes. This requires establishment and maintenance of effective processes for learning and for sharing good practice in relation to quality, safety and risk management.

Examples of good practice can be identified by, for example, frontline staff or by independent assessors. In some healthcare organisations, a library of good practice can be found, for example, on the organisation’s Intranet and this can be shared with other organisations. Internationally, some organisations establish regular ‘learning and sharing’ forums where staff can bring examples of good practice for discussion. Newsletters are also a good means for disseminating information for learning and sharing. Good practice can also be shared through third party organisations. For example, HIQA may, over time, become a portal for sharing information on good practice.

### 2.3.7 Check questions

The table overleaf contains ‘check questions’ that can be utilised by organisations to gain an understanding of their strengths and areas for improvement in relation to implementation of the core processes and programmes outlined above. The responses to these questions can be either ‘yes’, ‘no’, ‘partial’, ‘not applicable’ or ‘don’t know’. The ‘partial’ responses are categorised as ‘low’, ‘moderate’ or ‘high’. Where a no or partial response is provided, an action plan or ‘quality improvement plan’ (QIP) should be developed to implement any requirements. Where the question number box is shaded, this denotes that the response to the question may need to be made following the gathering and aggregation of appropriate information from a number of departments, service areas, etc. Further information on the assessment process is provided in the *Companion Guide* and also with the *Electronic Self-Assessment Tool*. 
<table>
<thead>
<tr>
<th><strong>Core processes and programmes: Check questions</strong></th>
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<tbody>
<tr>
<td><strong>G. Clinical effectiveness and audit</strong></td>
</tr>
<tr>
<td>1. <strong>Is a structured programme, or programmes,</strong></td>
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<td><strong>in place to systematically monitor and</strong></td>
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<tr>
<td><strong>improve the quality of clinical care</strong></td>
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<td><strong>provided across all services?</strong></td>
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<tr>
<td>2. <strong>Are arrangements in place to monitor</strong></td>
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<tr>
<td><strong>clinical effectiveness activity,</strong></td>
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<tr>
<td><strong>including clinical audit?</strong></td>
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<td>3. <strong>Is the implementation of evidence-based</strong></td>
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<td><strong>practice through use of recognised standards,</strong></td>
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<td><strong>guidelines and protocols</strong></td>
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<td><strong>promoted?</strong></td>
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<td>4. <strong>Are information systems</strong></td>
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<td><strong>being properly exploited to</strong></td>
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<td><strong>support clinical effectiveness activity?</strong></td>
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<td>5. <strong>Are clinical audits based on agreed</strong></td>
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<td><strong>selection criteria</strong> (e.g. high risk, cost,**</td>
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<td><strong>or volume; serious concerns arising from</strong></td>
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<td><strong>adverse events or complaints; new</strong></td>
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<td><strong>guidelines; local or national</strong></td>
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<td><strong>priorities; or patient focus)?</strong></td>
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<td>6. <strong>Is there evidence that clinical</strong></td>
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<td><strong>effectiveness activities result in</strong></td>
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<td><strong>changes in clinical practice and</strong></td>
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<td><strong>improvements in the standards of care?</strong></td>
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<tr>
<td><strong>H. Service user and community involvement</strong></td>
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<td>(NB –questions are adapted from the Victorian**</td>
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<tr>
<td>Health Safety and Quality Framework, Australia)</td>
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<tr>
<td>1. <strong>Is patient/service user and public</strong></td>
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<td><strong>feedback, including feedback on actual</strong></td>
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<td><strong>patient experience, regularly sought and</strong></td>
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<td><strong>integrated into quality, safety and risk</strong></td>
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<td><strong>management improvement activities?</strong></td>
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<td>2. <strong>Is sufficient information and opportunity</strong></td>
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<td><strong>provided for patients/service users to</strong></td>
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<td><strong>meaningfully participate in their own</strong></td>
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<td><strong>care?</strong></td>
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<td>3. <strong>Are patients/service users and the</strong></td>
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<td><strong>public involved in the development of</strong></td>
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<td><strong>patient information?</strong></td>
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<td>4. <strong>Are arrangements in place to train and</strong></td>
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<td><strong>support patients/service users, staff and</strong></td>
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<td><strong>the public involved in the patient and</strong></td>
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<td><strong>public involvement process?</strong></td>
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<tr>
<td>5. <strong>Are patients/service users and the</strong></td>
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<tr>
<td><strong>public invited to assist in planning new</strong></td>
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<tr>
<td><strong>services?</strong></td>
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### Risk management and patient safety

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<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Are risks of all kinds systematically identified and assessed in accordance with HSE guidance?</td>
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<tr>
<td>2.</td>
<td>Are risks of all kinds managed in order of priority in accordance with HSE guidance?</td>
</tr>
<tr>
<td>3.</td>
<td>Are risk registers used for the purpose of managing and communicating risk at all levels?</td>
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<tr>
<td>4.</td>
<td>Are arrangements in place to manage known high priority risk issues?</td>
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<tr>
<td>5.</td>
<td>Are staff-related occupational safety, health and welfare risks identified, assessed and managed and are arrangements in place to ensure the management of occupational health, safety and welfare?</td>
</tr>
<tr>
<td>6.</td>
<td>Are environmental and fire safety risks identified, assessed and managed and are arrangements in place to ensure that environmental and fire risks are minimised through meeting legislative and mandatory requirements?</td>
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<tr>
<td>7.</td>
<td>Is an ongoing programme of patient safety improvement in operation?</td>
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<tr>
<td>8.</td>
<td>Are arrangements in place to ensure that Medical Device Alerts/Safety Notices are circulated to all relevant staff and are acted on?</td>
</tr>
<tr>
<td>9.</td>
<td>Are incidents properly recorded and reported to management?</td>
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<td>10.</td>
<td>Are incidents managed in accordance with an agreed policy?</td>
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<tr>
<td>11.</td>
<td>Are incidents rated according to impact and reviewed, where appropriate, to determine contributory factors, root causes and any actions required?</td>
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<tr>
<td>12.</td>
<td>Are incidents subjected to periodic aggregate reviews to identify trends and further opportunities for learning, quality and safety improvement, and risk reduction?</td>
</tr>
<tr>
<td>13.</td>
<td>Are complaints, comments and appeals properly recorded and reported to management?</td>
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<tr>
<td>14.</td>
<td>Are complaints managed in accordance with an agreed policy?</td>
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</table>
15. Are complaints rated according to impact and reviewed, where appropriate, to determine contributory factors, root causes and any actions required?

16. Are complaints and comments subjected to periodic aggregate reviews to identify trends and further opportunities for learning, quality and safety improvement, and risk reduction?

17. Where appropriate, are all claims recorded and analysed to identify opportunities for learning, quality and safety improvement, and risk reduction?

**J. Staffing and staff management**

1. Are arrangements in place to ensure appropriate workforce planning?

2. Are arrangements in place to ensure appropriate recruitment procedures and induction training for staff appropriate to their roles and responsibilities?

3. Do the arrangements set out in questions 1 and 2 ensure compliance with related HSE and DOHC policy and guidance, professional and other codes of practice, and employment legislation?

4. Are continuing learning and development programmes in place and aimed at meeting the development needs of staff and services?

5. Are robust pre-employment checks carried out in line with national policy and the requirements set out in this framework?

6. Are arrangements in place to identify and deal with poor professional performance?

**K. Service improvement**

1. Are quality, safety and risk management goals clear, communicated effectively throughout the organisation and reflected in relevant service and business planning processes?

2. Do local quality, safety and risk management plans take account of identified national priorities?

3. Does the organisation participate in relevant external accreditation programmes?
Do quality improvement activities utilise a range of quality improvement tools to assist with assessing and diagnosing issues, identifying remedies and measuring improvement?

### L. Learning and sharing information

1. Does the organisation routinely learn from patient experience?

2. Does the organisation routinely learn from incidents occurring within the organisation and elsewhere?

3. Does the organisation regularly communicate to patients, staff and other relevant stakeholders improvements that have been made as a consequence from learning from patient experience and incidents?

4. Does the organisation share information and learning about serious incidents with other health providers and agencies?

5. Are arrangements in place for learning and for sharing information on good practice in relation to quality, safety and risk management?

### 2.4 Outcomes

#### 2.4.1 Key Performance Indicators (KPIs)

The ultimate test of effective systems for quality, safety and risk management is the extent to which they achieve improvements in outcomes or results for patients, service users and other stakeholders. Demonstration of improvements in quality, safety and risk management requires definition of key performance indicators (KPIs). Service providers should take a systematic approach to identifying a range of KPIs relevant to them.

In addition to locally developed KPI's all service providers across the HSE will be required to report against the following KPI\(^8\): “There is demonstrable improvement in compliance with this quality and risk management standard.” This KPI can be determined by using the electronic self assessment tool that accompanies this document. Effective management of

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\(^8\) This is taken from the HSE *Quality and Risk Standard* August 2007.
quality, safety and risk should result in demonstrable improvements in KPIs. Further information on KPI is contained in the *Companion Guide*.

### 2.4.2 Check questions

The table below contains ‘check questions’ that can be utilised by organisations to gain an understanding of their strengths and areas for improvement in relation to achieving the required outcomes from an integrated quality, safety and risk management system. The responses to these questions can be either ‘yes’, ‘no’, ‘partial’, ‘not applicable’ or ‘don’t know’. The ‘partial’ responses are categorised as ‘low’, ‘moderate’ or ‘high’. Where a no or partial response is provided, an action plan or ‘quality improvement plan’ (QIP) should be developed to implement any requirements. Where the question number box is shaded, this denotes that the response to the question may need to be made following the gathering and aggregation of appropriate information from a number of departments, service areas, etc. Further information on the assessment process is provided in the *Companion Guide* and also with the *Electronic Self-Assessment Tool*.

<table>
<thead>
<tr>
<th>Outcomes: Check questions</th>
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<tbody>
<tr>
<td><strong>M. Key Performance Indicators (KPIs)</strong></td>
</tr>
<tr>
<td>1. Have local KPIs been developed for quality, safety and risk management?</td>
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<tr>
<td>2. Are the KPIs monitored as part of ongoing quality, safety and risk management improvement activities?</td>
</tr>
<tr>
<td>3. Do the KPIs demonstrate that there is ongoing improvement in quality, safety and risk management?</td>
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