Quality and Patient Safety Directorate

July 2012
# Quality and Patient Safety Directorate

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Quality and Patient Safety (QPS) Directorate Role

The QPS Directorate is responsible for the development of a national integrated quality and risk management strategy for the HSE, driving the clinical governance framework to enable services to deliver on the quality and patient safety agenda and providing assurance to the CEO and the Board. The role of the Directorate is to provide leadership and to support the organisation in delivering on its objective of providing high quality and safe services to patients and service users. This role is delivered by:

- Determining recommended practices (within the context of the National Standards) and systems required for quality and safe care based on best evidence
- Building capacity within the organisation to deliver on the quality improvements
- Using data and evidence to monitor service quality
- Sponsoring a patient focus and service user participation
- Improving the sharing of information, the management of, and learning from, incidents to avoid reoccurrence
- Undertaking healthcare audits to provide organisational assurance

While it is the QPS Directorate role to determine and define systems and processes for quality and patient safety within the HSE, delivery is achieved through collaboration with other Directorates.

The Directorate has regular formal engagement with The Health Information Quality Authority (HIQA), State Claims Agency (CIS), Irish Medical Council, Dental Council, Radiation Protection Institute of Ireland, Department of Health (DoH), and other Regulatory Bodies to progress the quality agenda.

The QPS Directorate will have a central role in supporting all service providers in moving towards full and sustainable implementation of the National Standards for Safer Better Healthcare. The themes presented in the National Standards reflect common descriptions of quality used internationally and are becoming the framework for describing the principles of quality and safety for all healthcare settings. Service providers will use the National Standards as a framework to organise, manage and deliver their services safely. Over the next few years the focus of ongoing work across the system in the area of quality improvement, service provider evaluation and management of performance will progress the implementation of the standards on the journey towards a licensed system.

The Directorate structure and work plan is designed to ensure that there is a specific focus on supporting all key quality and patient areas as set out in the attached document. The purpose of this document is to identify QPS Staff Roles and Contact Details to ensure that the leads on various aspects of our work are accessible to those in the system requiring support.

If you would like more information about any of our work, please contact us directly (names and contact details are provided in the document) or see the Website: http://www.hse.ie/eng/about/Who/qualityandpatientsafety
The Quality and Patient Safety work plan is ambitious and covers a wide range of programmes and projects. The key commitments, set out in the 2012 Service Plan are:

- Promoting the role of Clinical Governance and developing Clinical Leadership
- Ensuring safe services (a point of contact for clinicians in dealing with clinical issues and encouraging and recognising patient safety initiatives, HCAI, Medication safety, etc)
- Monitoring the Quality and Patient Safety performance of the system
- Integrated risk management (Complaints/incidents, risk registers, audit)
- Building a Learning culture
- Embedding national standards and HSE recommended practices
- Building further capacity to support the work of the Directorate
- Support the development of the Patient Safety Authority through engagement with DoH and HIQA.
- the widening use of the Health Intelligence Ireland information system and National Quality Assurance Intelligence System (NQAIS) to help drive quality, safety, and efficiency of health services.

The Directorate is committed to developing a service improvement culture in our health system. A key priority is the development of comprehensive systems for collection, analysis, and processes to extract the key learning from complaints, incidents, reports, reviews/investigations and other sources to form the basis of a learning system, in collaboration with other Directorates in the HSE. This will then be disseminated throughout the organisation to ensure such learning is used for the improvement of patient care. The Directorate structure and work plan is designed to ensure that there is a specific focus on all relevant areas.

Website: [http://www.hse.ie/eng/about/Who/qualityandpatientsafety](http://www.hse.ie/eng/about/Who/qualityandpatientsafety)

### Education & Training

The Diploma in Leadership & Quality in Healthcare has been developed with the support of the Quality and Patient Safety and Clinical Strategy and Programme Directorates in the HSE. The aim of the Diploma in Leadership & Quality in Healthcare is to develop an initial cohort of Irish Clinicians to provide the foundation for building internal capacity and capability for quality improvement in Ireland. This course has been designed to meet the needs of the Irish health system in improving the outcomes for patients.
### National Standards for Safer Better Healthcare

The Quality and Patient Safety Directorate has an important role in ensuring continuous quality improvement within health services by supporting the implementation of National Standards. This role has leadership and facilitation aspects and involves working collaboratively with service providers, regulatory bodies that set National Standards (e.g. Health Information and Quality Authority and the Mental Health Commission), national clinical programmes, professional colleges, service user groups and the Department of Health. This collaboration informs learning and best practice as well as the development of supportive networks for implementation of National Standards.

The recently launched National Standards for Safer Better Healthcare (NSSBH) provide an underpinning framework for continuous improvement in the quality and safety of healthcare services (excluding mental health services). They describe the principles of quality and safety for healthcare settings which can be understood and shared by the public, service users and service providers. The Quality and Patient Safety Directorate will be working with all key stakeholders to develop a consistent approach to implementing these National Standards.

### Contact details

**Dr. Mary Browne**  
Consultant in Public Health Medicine  
E-mail: mary.browne7@hse.ie  
Tel: 01 6352131

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### Clinical Governance Development

**What is clinical governance**  
*Improving quality and protecting patients from harm is the job – clinical governance delivers the leadership and accountability frameworks to achieve this.*

Clinical governance is described today as:  
*A framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered.*

For health care staff this means:  
*Specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do.*

**The vision for clinical governance development is:**

- Each individual, as part of a team:
  - knows the purpose and function of leadership and accountability for good clinical and social care;
  - knows their responsibility, level of authority and who they are accountable to;
  - understands how the principles of clinical governance can be applied in their diverse practice;
  - consistently demonstrates a commitment to the principles of clinical governance in decision making
- A culture of trust, openness, respect and caring is evident among managers, clinicians, staff and patients
- Clinical governance is embedded within the overall corporate governance arrangements for the statutory and voluntary health and personal social services in realising improved outcome for patients.

We have established a working group, steering group and an international reference panel for a targeted...
clinical governance development initiative over a two year period to June 2013. We work closely with the Integrated Services Directorate, Regional Managers for Quality and Patient Safety, the National Clinical Programmes, the Special Delivery Unit, Clinical directors/directorate development and key stakeholders across the health service.

Supporting the implementation of clinical governance within identified hospitals/groups
A framework for clinical governance development is being developed in collaboration with health service providers. The framework is made up of a vision, principles, matrix and an assurance check for clinical governance development – set out in two publications
- Quality and Patient Safety: clinical governance information leaflet
- Quality and Patient Safety: clinical governance development assurance check for health service providers.

During 2012 concentrated support will be provided to a small number of hospitals/groups in testing and expanding the materials/approach to clinical governance development.

We also provide guidance, on request, to health service providers on matters related to clinical governance. Further information is available at: [http://www.hse.ie/go/clinicalgovernance](http://www.hse.ie/go/clinicalgovernance)

### Clinical Director Programme

| The introduction of the clinical directorate model, incorporating the appointment of Clinical Directors with formal authority to lead, is one of the most significant changes to occur in the Irish Healthcare Service for many years. Clinical Directors have made significant contributions to the development of the health services. It is vital, that the development of the Clinical Directorate model which underpins the development of the Directorates and the appointment of the future Clinical Directors is fully supported so that it can mature in a structured, co-ordinated and timely manner. The underlying principle of the Clinical Director model is that of a single point of accountability. |
| Contact details |
| Thora Burgess |
| Clinical Director Programme Manager |
| 01 2744310 |
| thoraburgess@hse.ie |

**Supporting the Clinical Director Programme**

The Clinical Director programme is part of the QPS Directorate and a number of supports for the Clinical Directors have been put into place.

- Appointment of a Programme Manager
- Appointment of a National Programme Lead, Dr Colm Henry, for the Clinical Director programme. Dr Henry is a Consultant Geriatrician in the Mercy University Hospital, Cork, he was also appointed as a Clinical Director of the Mercy University Hospital, Cork as part of the first wave of appointments nationwide in early 2009. He is expected to take up his new role early September 2012
- This role will ensure the evolution of clinical leadership is managed in a structured way and that there will be national leadership in implementing the roll out of Clinical Directors so that their role is fully integrated into health management structures.
- Establishment of a Joint HSE/Forum of Irish Postgraduate Training Bodies Clinical Director Working Group to provide recommendations and develop material for consideration by the Clinical Director Steering Committee.
- Quarterly Joint HSE/Forum Clinical Director Steering Committee

**The Clinical Director /Directorate model at a national level.**

The QPS focus is on progressing the developments in clinical leadership and clinical directorates at a national level. During 2012 support will be provided to the clinical directors and the hospital groups to help in shaping the development of clinical directorates Currently the national approach is focusing on:

- Providing clarity around the role of the clinical director,
Providing support to the clinical directors
Looking at developing an education framework suitable for the clinical directors.
Communicating the importance of clinical leadership across the system.

National Advocacy Unit

The primary role of the National Advocacy Unit is:
- to ensure that the involvement of service users is central to how health care services are designed, delivered and evaluated,
- to develop and support implementation of best practice models of customer care within the health service,
- to support implementation of the National Healthcare Charter, You and Your Health Service which outlines what service users can expect and what their responsibilities are whenever and wherever they use health services,
- to develop organisational capacity, to gather patient feedback and to use this information to improve services for service users,
- to encourage service user involvement on patient forums,
- to support the development of a national network of patient safety champions,
- to support implementation of advocacy programmes in health care settings
- to improve access to health services,
- to promote clear communication between health care providers and patients following an adverse event in health services,
- mediation and facilitation for complaints handling.

Many of the team members are designated review officers under Part 9, Health Act 2004. We also have links with the Regional Managers for Consumer Affairs and Quality and Risk Managers and key stakeholders across the health service.

Central Office, National Advocacy Unit
The National Advocacy Unit central team is responsible for the support and administration of:
- Your Service Your Say complaints,
- public reps,
- requests for reviews of complaints.

The team also provides advice to members of the public.

Implementation of the National Healthcare Charter You and Your Health Service
Our work on service user involvement is continually developing. At the moment we are leading on the:
- implementation of the National Healthcare Charter, You and Your Health Service - What you can expect from your health service and what you can do to help
- implementation of the National Strategy for Service User Involvement
### Complaints under the Disability Act 2005

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<th>Suburb</th>
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<tr>
<td></td>
<td>Angela Kennedy</td>
<td>045 880 457</td>
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<td></td>
<td><a href="mailto:shane.shannon@hse.ie">shane.shannon@hse.ie</a></td>
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The Disability Act 2005 provides for a special complaints and appeals procedure which you can use if you are unhappy with your child's assessment of need or Service Statement. It also provides a process for dealing with complaints about access for people with a disability.

You can make a complaint after you have submitted a completed assessment of need application form to the Assessment Officer if you are dissatisfied.

### Open Disclosure / Mediation

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<td></td>
<td>Angela Tysall</td>
<td>074 918 90 13</td>
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We want our services to support an open, timely and consistent approach to communicating with patients and their families when things go wrong in healthcare. This is called open disclosure.

We are working with the State Claims Agency to develop and pilot new guidance on Open Disclosure at two sites, the Mater Misericordiae University Hospital and Cork University Hospital. This guidance will then be implemented nationally across all of our health services.

We are also working to explore and develop the use of mediation in relation to the management of complaints as per Part 9 of Health Act 2004.

### Patient and Service User Feedback: Policy, Procedures and Guidance; Information Management and Training

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<td></td>
<td>Wini Ryan</td>
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<td><a href="mailto:winifred.ryan@hse.ie">winifred.ryan@hse.ie</a></td>
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<tr>
<td></td>
<td>Juanita Guidera</td>
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<td><a href="mailto:juanita.guidera@hse.ie">juanita.guidera@hse.ie</a></td>
</tr>
<tr>
<td></td>
<td>Nicola Williams</td>
<td>052 6125749</td>
<td><a href="mailto:nicolaj.williams@hse.ie">nicolaj.williams@hse.ie</a></td>
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The National Lead for Patient and Service User Feedback has responsibility for the management of feedback including comments, compliments, complaints and reviews received through the National Advocacy Unit, Naas and the CEO’s office.

We design and develop policies and procedures and guidance for complaints and review officers to support their role under the Health Act 2004. This includes:

- a consultative review of the HSE Policy and Procedures for the Management of Consumer Feedback;
- the development of policies and procedures to support the identification and management of unreasonable complainant behaviour; and
We are looking at ways to enhance information management to encourage organisational learning from national statistics for complaints and reviews. We are currently developing the categorisation of complaints and an IT System to support data reporting under the 8 principles of the National Healthcare Charter – You and Your Health Service.

### Patient Safety Champions

**Liaison Office of the Ombudsman and Office of the Ombudsman for Children**

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<tr>
<th>Mila Whelan, Office Manager</th>
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<td><a href="mailto:mila.whelan@hse.ie">mila.whelan@hse.ie</a></td>
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We are establishing a group of patient safety champions. This group will work with health care professionals to help raise awareness of and promote international patient safety standards.

This initiative is based on the World Health Organisation (WHO) model of Patients for Patient Safety.

### Research

**Research Officer**

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<th>Rachel McEvoy, Research Officer</th>
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<tr>
<td>Tel: (091) 775139</td>
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<tr>
<td><a href="mailto:rachel.mcevoy@hse.ie">rachel.mcevoy@hse.ie</a></td>
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Work is continually underway to critically analyse service user involvement and related projects/initiatives with the support of Health Research Board (HRB) funding. We are currently working in collaboration with the Graduate Entry Medical School (GEMS) in University of Limerick.

### Service User Involvement in Clinical Care

**National Lead Service User Involvement**, **Geri Quinn**

| Tel: 045 880 544 |
| june.boulger2@hse.ie |
| geraldinmary.quinn@hse.ie |

A national patient forum has been established to ensure that service users have the opportunity to inform the design, delivery and evaluation of the National Clinical Care Programmes. Many people who use our services have chronic conditions. We are currently involved in mapping the existing self-management support services and programmes for people living with chronic conditions and their families. This work is being completed in partnership with the National Patient Support Organisations.

The information generated will inform and guide the development of a generic Framework for Self-Management Support for the National Clinical Care Programmes.

### Third Age National Advocacy Programme

**Programme Manager**

<table>
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<th>Anne Harris, Programme Manager</th>
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| june.boulger2@hse.ie |
| geraldinmary.quinn@hse.ie |
The Third Age National Advocacy Programme aims to deliver a representative advocacy service to older people in Nursing Homes.

This initiative is provided to the homes involved under the auspices of Third Age, Nursing Homes Ireland and the HSE. Further information is available on the Third Age website www.thirdageireland.ie

### Universal Access

| Caomh Gléeson,  
National Specialist in Accessibility  
Tel: 071 982 0266  
caomh.gleeson@hse.ie |
|---|

We are responsible for the provision of guidance, advice and strategic support in the promotion of access for people with disabilities in mainstream health services and provide support for compliance with Part 3 of the Disability Act 2005.

We also have a role in developing policy and practice on a range of equality issues including Lesbian, Gay, Bisexual and Transgender health

### Quality Unit

| The role of the Quality Unit is:  
Determining recommended practices for specific areas (within the context of the National Standards) and systems required for quality and safe care based on best evidence. The focus is also on supporting service providers in quality improvements and initiatives and in complying with statutory requirements in relation to areas such as patient radiation protection. The unit is developing a Quality Profile and process for monitoring the performance of service providers against standards / compliance requirements as part of the provision of organisational assurance with regards service quality.  
The team, outlined below, are also available to provide advice in relation to their work area.  
Fionnuala Duffy,  
Assistant National Director  
Tel: 01 6352458  
Fionnuala.duffy1@hse.ie |
|---|

### Patient Radiation Protection Programme

| Ciara Norton,  
Patient Radiation Protection Lead  
Tel: 01 6201807  
Ciara.norton@hse.ie  
Tel: 045 882570,  
Rachel.brennan1@hse.ie |
|---|

Statutory Instrument 478 (2002) gives regulatory responsibilities to the HSE for Patient Radiation Protection for all medical radiological practices in the public and private sector in Ireland, these responsibilities include:

- Establishment and support of the National Radiation Safety Committee
- Conduct external clinical audit every five years
• Receive the advice of the National Radiation Safety Committee and implement recommendations for patient safety, such as production of national guidelines and publications.
• Manage National Statutory Incident Reporting of patient radiation incidents.
• Publish an annual report on Population Dose from patient ionising radiation.
• Maintain a national database of all medical radiological equipment and holders in Ireland
• Work with national and international statutory and professional bodies such as the Radiological Protection Institute of Ireland, the Department of Health and Children, the Health Information and Quality Authority, the Medical Council, the Dental Council and the Faculty of Radiologists to produce, promote and monitor guidelines on practice.

The Medical Exposure Radiation Unit (MERU) was established as a result of the introduction of Statutory Instrument 478. The MERU supports the CEO, HSE and National Radiation Safety Committee to meet its regulatory requirements to protect patients from the potential harmful effects of exposure to all medical ionising radiation, through regulation, monitoring and advice. The Unit focuses its effort on practices that pose a higher risk for the patient - radiotherapy and high dose procedures such as CT and Nuclear Medicine. The current workload of the Unit is outlined below:

National Radiation Safety Committee (NRSC)
• Service NRSC including Radiotherapy, Clinical Audit, Population Dose and Dental Subcommittees
• Renew membership and governance as required
• Provide advice and research to committees as requested
• Implement the recommendations of the Committee that are approved by the CEO, HSE

National Clinical Audit in Radiation Protection
• Develop clinical audit guidelines, self assessment questionnaires and templates for implementation of clinical audit in all areas of medical radiological practices
• Conduct regular national clinical audit in radiotherapy, nuclear medicine, radiology, dentistry and chiropractic

Population Radiation Dose
• Survey, analyse and publish radiation dose to the population from radiological procedures on an annual basis
• Provide the Irish contribution to European Commission population dose publications

Manage Statutory Patient Incident Reporting in Diagnostic Radiology, Nuclear Medicine and Radiotherapy
• Continued development and implementation of statutory incident reporting guidelines
• Receive and monitor incident reports and advise on investigation
• Review investigations and distribute learning from incident reports

Monitor compliance in patient radiation protection
• Monitor compliance of all holders by audit

Set guidelines in Patient Radiation Protection
• National Guidelines on Responsibilities for Patient Radiation Protection
• National Guidelines on Radiological Clinical Audit
• Joint Guidelines on Radiation Practices with the RPII
• Guidelines for Medical Physics Expert in Dentistry
Medication Safety Programme

The Medication Safety Programme is charged with making practical improvements to the way medicines are managed, to deliver better, more efficient care for patients and avoid harm. The Programme is leading on a number of initiatives including the standardisation of Medication Prescriptions & Administration Records (MPAR) in acute hospitals (including acute mental health facilities) to minimise medication errors caused by documentation processes. The Programme is also addressing the introduction of technology to underpin safe, efficient work practices in medication management. These technologies include electronic prescribing with decision support, automated dispensing systems, bar-code technology in drug administration and the seamless electronic communication of data throughout the patient journey.

Key work priorities also include:

- Implement medication reconciliation at transitions of care between hospitals, long-stay facilities and the community to reduce errors at hand-over of care
- Develop a national Medication Safety Standard for Acute Hospitals and a Self-Assessment Tool.
- Establish an audit to assure compliance with safe practice guidance on oral methotrexate for non-cancer treatment (arthritis and psoriasis) in the community.
- Assist the National Cancer Control Programme in designing a system of safe management of Oral Anticancer Medicines for cancer patients.
- Develop a practice research programme in collaboration with the universities to ensure that there is a robust collection of evidence to support changes to the way medications are managed.

A Medication Safety Advisory Group is in place to provide expert advice on the rollout of the National Medication Safety Programme

| National Consent Policy          | Angela Hughes,  
|                                | National Quality Lead  
|                                | Tel: 042 9385460 
|                                | Angela.Hughes@hse.ie |

A National Consent Advisory Group has been established to review existing policies, guidelines, national and international evidence of best practice, relevant bioethical and legal opinion pertaining to the issues of...
The issue of consent to examination and treatment in health and social care is highly complex. The aim of the consent programme is to propose a national consent policy, supporting documentation and expert advice on the implementation and monitoring of the policy. A national consent policy and supporting documentation has been developed and went out to public consultation in May – June 2012. The final policy will be informed by the feedback and is expected to be completed by September 2012.

**Integrated Care / Discharge Planning**

A National Integrated Care Advisory Group is in place to review the existing Integrated Discharge Planning Standards and Recommended Practices and update these documents in the context of recent developments in the HSE at corporate and regional level and in view of the forthcoming licensing requirements as directed by the National Standards for Safer Better Healthcare.

**Healthcare Records Management**

A National Healthcare Records Management Advisory Group is in place to provide expert advice on the rollout of the National Healthcare Records Management Programme. Healthcare records are a valuable resource because of the information they contain. The aim of the healthcare records management programme is to provide a framework for consistent, coherent healthcare records management in the Health Service Executive which in turn will support a high quality service. The programme has, and will continue to, develop and implement initiatives to improve healthcare records management and promote service user safety.

Within services, the healthcare record plays a crucial role and performs a number of functions in that it:

- Maintains the history of service user care.
- Records decisions relating to the care plan of the individual.
- Supports the workflow of the clinical and administrative functions within the service for healthcare professionals and staff.
- Supports continuity of care and facilitates communication between all members of the multidisciplinary team.
- Supports communication with external sources of health and social care information such as laboratory and radiology departments as well as consultations and referrals with colleagues.
- Justifies care delivery in the context of legislation, professional standards, guidelines, evidence, research and professional and ethical conduct.

Well managed records set the tone of an organisation and this is particularly so in the health service. Not only do the healthcare records themselves need to be managed from their creation and registration through to storage, security, confidentiality, retrieval and transportation, but what’s contained within is of vital importance and must also be managed and maintained. The aim is to have a unified healthcare record for each patient that will reduce error and improve patient safety and quality of care. In this regard a standardised national healthcare record was developed and implemented in the acute hospitals across the country. It was reviewed and updated following nationwide consultation in 2011 and is due to be reviewed again in 2014.

The Standards and Recommended Practices for Healthcare Records Management V3.0 were circulated through the office of the RDOs for implementation locally in the summer of 2011. Because standards and
practices in relation to healthcare records management will change over time, this document will evolve to reflect those changes.

An e-learning foundation training programme developed to support the Healthcare Records Management Programme and help staff to improve their performance in relation to healthcare records management can be accessed at [www.hseland.ie](http://www.hseland.ie)

Guidance regarding any aspect of healthcare records management is available through the programme lead, if required

**National Maternity Healthcare Record**

A National Maternity Healthcare Record (NMHCR) has been developed in 2011 and circulated through the office of the RDOs for implementation in all HSE funded maternity hospitals/units. The introduction of a standardised chart is a significant factor in improving maternity care nationally. The NMHCR will help to improve quality of care as staff move between hospitals. It will also assist in the collection of standardised data in maternity hospitals/units and facilitate future research into maternal and foetal health. The NMHCR is a unified healthcare record that supports continuity of care and facilitates communication between all members of the multidisciplinary team.

- The NMHCR Working Group will co-ordinate and consider feedback from users and recommend and organise any amendments to the NMHCR following the first review (January 2013).
- Evaluation of the NMHCR is being conducted from January 2012 to December 2012 (inclusive).
- A national chart tender process will be undertaken to streamline supply and achieve value for money following first review in January 2013.

Guidance regarding implementation of the national maternity healthcare record is available through the programme lead, if required.

<table>
<thead>
<tr>
<th>Decontamination of Reusable Invasive Medical Devices (RIMD) programme</th>
<th>Joy Markey, National Decontamination Lead</th>
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<tbody>
<tr>
<td></td>
<td>Tel: 01 6352238, <a href="mailto:Joy.Markey@hse.ie">Joy.Markey@hse.ie</a></td>
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**Decontamination of Reusable Invasive Medical Devices (RIMD) programme**

A National Decontamination of RIMD Advisory Group is in place to provide expert advice on the rollout of the National Decontamination of RIMD Programme. The aim of programme is to improve the quality of patient care and provide a safer working environment for service providers. Decontamination of RIMD relates to this by:

- **Prevention and control of healthcare-associated infection (HCAI)**
  Decontamination is essential to ensure that RIMD are free from infective micro-organisms and bacterial endotoxins. Effective decontamination of RIMD before their use on the next patient is an essential measure in the prevention of HCAI.

- **Staff safety during handling and use**
  RIMD must be cleaned and disinfected to ensure that they are safe for staff to handle during inspection, assembly, packaging and use.

*The HSE Standards and Recommended Practices for Decontamination of RIMD, V2.1* was circulated in 2011 following consultation and review of the *HSE Code of Practice for Decontamination of RIMD, V1.0.*
The purpose of this document is to set out a standardised approach to decontamination practices, ensuring decontamination of RIMD which are fit for purpose and which will allow healthcare organisations to meet the requirements of the E.C. Medical Devices Directive and the HSE Decontamination Programme.

The Decontamination programme also supports private healthcare organisations on an ongoing basis and has included the consultation process for development of Standard for decontamination. Guidance regarding implementation of the decontamination recommended practices is available through the programme lead, if required.

<table>
<thead>
<tr>
<th>Post Mortem Examination Services Programme</th>
<th>Joan Malone, Post Mortem Examination Services Programme Lead Tel: 01 6352315 <a href="mailto:Joan.malone1@hse.ie">Joan.malone1@hse.ie</a></th>
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Post Mortem Examination Services Programme
Post mortem examination is an important part of clinical care. It is one of the most informative investigations in medicine and can provide objective information on the cause of death which is of value to the family of the deceased and to healthcare professionals.

The overall aim of this programme is to drive high quality post mortem examination services, through defining and supporting the embedding of good practice in key areas relevant to post mortem examinations (coroner and hospital) and supporting an effective interface between service providers and the Coronial System in relation to coroner’s post mortem examinations. A Post Mortem Examination Advisory Group was established in November 2009 to review previous guidance in light of the findings and recommendations contained within these key reports and to oversee the development and implementation of standards and recommended practices for post mortem examinations.

HSE Standards and Recommended Practices for Post Mortem Examination Services, V1.0 was developed in 2011 following extensive review of relevant literature and consultation with key stakeholders. This document reflects the learning from key reports on post mortem practice and procedures was circulated through the offices of the RDOs in March 2012.

Guidance regarding implementation of the Standards and recommended practices for post mortem examination services is available through the programme lead, if required

<table>
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<tr>
<th>Clinical Audit Support Programme</th>
<th>Joan Malone, Clinical Audit Programme Lead Tel: 01 6352315 <a href="mailto:Joan.malone1@hse.ie">Joan.malone1@hse.ie</a></th>
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Clinical Audit Support Programme
A National Clinical Audit Advisory Group is in place to oversee the development of clinical audit in the HSE and the creation and dissemination of guidance, education and training in the area of clinical audit of healthcare. The primary aim of this programme is to provide support for clinical audit across acute and primary care services.

Clinical Audit Support will be provided by:
- Educating individuals and groups in clinical audit theory and practice
- Advising on audit design and process through guidance documentation and reference material
• Identifying existing sources of information, literature and electronic information systems on individual projects and on audit in general
• Facilitating the sharing of clinical audit tools and experiences across sites.

The Directorate recently invited stakeholders to review and submit feedback on the draft National Clinical Audit Guidance Document as part of a web based national consultation process.

Guidance regarding clinical audit is available through the programme lead, if required

National Office for Clinical Audit (NOCAS)
Tel: 01 6352385/2111
Maeve.raeside@hse.ie

National Office for Clinical Audit (NOCAS)
The National Office of Clinical Audit has been established through the collaboration of the HSE’s Quality and Patient Safety Directorate and Clinical and Strategy Programmes Directorates together with the Royal College of Surgeons in Ireland and the College of Anaesthetists. The Royal College of Surgeons in Ireland will be responsible for the administration and operation of NOCA on behalf of the HSE.

Structured clinical audits will provide NOCA with the tools needed to report on the outcomes of the audits in order to ensure shared clinical learning experiences. Promoting a culture of lifelong learning and peer review will help to create an open culture of identifying and reporting incidents in order to provide the best care for patients.

The establishment of a National Office of Clinical Audit reaffirms the on-going commitment to assessing openly how health services compare against high quality standards, so that any changes needed to improve the quality of care can be identified and acted upon. This is part of a continual learning process, which is very much in keeping with the commitment to patient safety first.

The first audit stream under development is the Irish Audit of Surgical Mortality. This confidential, independent, peer review audit will provide documented, critical analysis of the outcomes of surgical care. It will allow for the detection of system issues and emerging trends and will enable Irish clinicians to benchmark clinical outcomes against international standards.

Three additional audit streams have been identified for 2012.

i. An Irish National Orthopaedic Register – a national register to record and monitor joint replacement.

ii. A national Intensive Care Audit – to monitor patient care and outcomes in intensive care

iii. Average Length of Stay – collation of data from the average length of stay element of the Elective surgery programme to inform efficient bed usage in hospitals

Paediatric Service Quality Improvement
Helen Byrne, Paediatric Services Programme Lead
Tel: 01 6201658,
HelenM.byrne@hse.ie

Paediatric Service Quality Improvement
The Directorate provides support for the development and implementation of the national paediatric model of care ensuring that quality and safety for children is at its core. This includes:
• A national policy for the delivery of ‘Safe Surgery’ for Children for non-specialist paediatric surgery

• Irish Paediatric Critical Care Network to include clinical audit standardisation that will improve the integration, harmonisation and modernisation of the information systems in both Paediatric Intensive Care Units (PICUs) to facilitate patient safety systems and to facilitate quality control processes

• Clinical Review of Paediatric Critical Care Services in Dublin

• Working towards operating an all Ireland paediatric congenital cardiac surgery clinical network that will ensure a safe and sustainable service on an all island basis.

• Input to the National Paediatric Hospital Service Improvement Group and Development Board.

Guidance regarding quality in paediatric services is available through the programme lead, if required

**Quality Monitoring Function**

Ruth Maher,  
Head of Monitoring  
Tel: 01 6352457,  
Ruth.maher@hse.ie

**Quality Monitoring Function**  
The purpose is to provide a process and framework by which the Directorate will plan and monitor the quality performance of service providers across all sectors of the HSE against National Standards/compliance requirements and to produce quality performance reports to inform the development and review of patient safety initiatives. This includes:

• Develop systems to measure quality performance against specific standards/compliance requirements;
• Provide analysis reports on performance against specific standards and quality performance as required;
• Undertake comparative trend analysis of reviews/reports/ and compliance reporting to identify areas of excellent/good practice or areas of potential weakness or risk
• Assist in the development of patient safety initiatives through the above analysis reports
• Support the development of systems to ensure the organisation is prepared for future licensing, meeting standards requirements and ensuring that HIQA, DoH and other regulatory requirements are reviewed and acted upon as appropriate;
• Liaise with other Directorates to provide support for service providers undertaking assessments against National Standards;
• Undertake comprehensive reviews of self assessments by service providers against HSE & National Standards as required
• Monitor the updates against key external reports/reviews recommendations in order to track the implementation of report recommendations.

**Quality Indicators and National Quality Profile**

• Develop quality and patient safety indicators in collaboration with key stakeholders both within and external to the HSE through the National Quality Indicator Steering Committee and Technical Group.
• Provide support to the National Quality and Patient Safety Indicator Committee, which has been established in collaboration with the DoH and has invited membership from both HSE funded
agencies and independent agencies and HIQA, to develop a National Suite of Quality and Patient Safety Indicators for use by Health Service Providers.

- Chair the National Quality and Patient safety Indicator Technical Group which will support the National Quality and Patient Safety Indicator Committee with its work in consultation and collaboration with key stakeholders.
- Develop a National Quality Profile to provide clear and meaningful data around a number of key areas including quality indicators. This profile will form part of a report on the quality of services provided by a healthcare service, with the aim of engaging leaders within organisations around the quality agenda while at the same time providing increased accountability to the public.

**Compliance Registry/Repository**
A key piece of work currently under way is scoping and developing a Compliance Registry/Repository to include national/international legislation, standards and compliance requirements in collaboration with other Directorates in the HSE and other agencies.

**Patient Safety Culture Survey**
The Directorate is leading on the implementation of a National Patient Safety Culture Survey for staff. A pilot of this staff for Staff working in Acute Hospitals commenced in June with a plan to roll out the survey to all acute hospitals later in the year following an evaluation of the pilot to test the methodology and data collection methods. It is planned to expand this survey to Primary Care over the coming year.

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<tr>
<th><strong>Health Care Acquired Infection H C A I</strong></th>
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<tr>
<td>Tackling MRSA and Health Care Associated Infection (HCAI) is a priority for the HSE and as a result of the <em>Say No to Infection</em> campaign the HSE has established a HCAI programme. Its core objectives are:</td>
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| - To reduce Health Care Associated Infections  
- To reduce MRSA infections  
- To reduce antibiotic consumption |
| These targets will be achieved through the development of national and local level action plans to reduce the potential for spread of infections between persons in health care settings and to reduce and alter antibiotic use in Ireland. The immediate priorities for the programme are: |
| 1. Use antimicrobials appropriately (antimicrobial stewardship)  
2. Prevent medical device-related infections i.e., IV lines and urinary catheters  
3. Improve hand hygiene by healthcare staff |
| The clinical lead for the programme, Dr. Fidelma Fitzpatrick, is a joint appointment between the Royal Colleges and the HSE |
| **Dr. Fidelma Fitzpatrick**  
RCPI and HSE Clinical Lead, Prevention of Healthcare-associated Infection Medical Council no 17361  
Consultant Microbiologist, Beaumont Hospital and Health Protection Surveillance Centre, Dublin Ireland  
Tel: 01 8765300  
Fidelma.fitzpatrick@hse.ie |

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<tr>
<th><strong>National Organ Donation and Transplantation Office</strong></th>
<th><strong>Contact details</strong></th>
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<tr>
<td>In 2011, following agreement with the DOH, the National Organ Donation and Transplantation Office was established. This office sitting under the Quality and Patient Safety Directorate will oversee the implementation of the EU Directive on 2010/53/EC on standards of quality and safety of</td>
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| **Professor Jim Egan**  
Director  
Consultant in Respiratory |
human organs intended for transplantation by August 2012. In conjunction with the EU Directive the National Organ Donation and Transplantation Office must:

- Provide a cohesive approach to Organ Donation and Transplantation Services nationally.
- Maintain Deceased Organ Donation Rates +/-10%
- Increase Living Renal Transplant Programme Rate to 50% of Deceased
- Increase Heart Lung conversion rates to 50%
- Develop a National Database capturing all organ donation and transplantation data
- Engage internationally to ensure benchmarking against best practice and outcomes
- Deploy Donor Champions for Organ Donation throughout the acute system for both Medical and Nursing roles.
- Establish a Curriculum Group with the Nursing and Midwifery Services Directorate as part of the CPD for Nurses
- Engage with the Intensive Care Society to establish a Potential Donor Audit across all Critical Care Units
- Establish a formal National Procurement Organisation which reports to the National Organ Donation and Transplantation Office

Health Intelligence Unit

Health Intelligence is the development and use of knowledge to support decision making to improve the health of the population. The Health Intelligence Team work to support the health system to make good decisions for better health and social care by using the evidence base of health. The objectives of the team are:

- Production/ development of evidence-based analyses/ products/ reports/ surveys/ methodologies that inform key strategic and operational decision-making needs, including further use and development of the Health Intelligence Ireland information system which is currently supporting development of NQAIS (the National Quality Assurance Intelligence system)
- Enabling health service staff use a range health intelligence, evidence, and knowledge for health, through information and knowledge systems, facilitation of groups/ teams in decision-making/ change processes, interventions to get research into practice, and targeted skills training.
- Enabling Research & Development in the health system through direct working with internal HSE research structures, and linkages with external research bodies (participation in steering groups and authorship of research papers).

Priorities for 2012 and beyond are -

- the widening use of the Health Intelligence Ireland information system and NQAIS to help drive quality, safety, and efficiency of health services;

Contact details

Dr Davida De La Harpe
Head of Health Intelligence
01 620 1809
davida.delaharpe@hse.ie
www.healthintelligence.ie

Email is the preferred method of contact for members of the Health Intelligence team
- the expert review of clinical and health services evidence in collaboration with the clinical programmes and other service delivery units of the health service
- working directly in an advisory, facilitation, and project management role with clinical programmes and care group service leads on key pieces of work.

The Team will be engaged in numerous journal publications and conference presentations in 2012.

| Health Intelligence Ireland Information System, now incorporating NQAIS | Ian.folan@hse.ie  
Howard.johnson@hse.ie |
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<td>After more than 5 years of continuous development, starting with the original Health Atlas System, the Health Intelligence Ireland system in 2011 expanded rapidly in the breadth and complexity of the analytic facilities delivered and the numbers of end-user groups gaining direct value. Examples of recent developments include modules for analysis of elective surgery activity and quality assurance of histopathology. The rapid expansion of the system and its uses will continue in 2012.</td>
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</table>
| Clinical Evidence Review | Anne.farrell@hse.ie  
Declan.mckeown@hse.ie  
gerardine.sayers@hse.ie |
| The team is engaged on a daily basis in providing advice and guidance by way of review of clinical evidence. An example of is in relation to the E112 (Treatment Abroad) Scheme which is now administered on a national basis. The team also provides bio-statistical analysis of large data sets in order to inform evaluation of the effectiveness of health policy and strategy and to drive recommendations for action. This type of analysis is provided to the clinical programmes, for example in relation to COPD to highlight some improvements in morbidity for men, but a concerning trend in presentations by women. Such analyses will be continued in 2012, on topics requested by the clinical programmes as well as in response to new international data and reports. |  |
| Advice, Facilitation, Study Design, Analysis & Project Management | Dougie.beaton@hse.ie  
Catherine Hayes (hayese9@tcd.ie)  
Siobhanmary.mccarthy@hse.ie  
Declan.mckeown@hse.ie  
Maryc.morrissey@hse.ie  
Louise.mullen@hse.ie |
| The team provides assistance to clinical programmes and care groups leads on an ongoing basis. Prominent examples of work ‘in hand’ that will continue into 2012 include – |  |
| - **Audit of Client Protection Measures in Intellectual Disability Organisations** - continued data analysis and leadership on handling of issues arising following extensive survey of practice in 2011. |  |
| - **Pilot of Single Assessment Tool for Older Persons** – Completion of pilot study of use in practice of interRAI™ assessment and care planning decision-support tools using computerised platform, and completion of Business Case for implementation. |  |
| - **Cancer Programme** – provision of research study expertise to the National Cancer Control Programme. |  |
| - **Disability Services** – Direct support to care group lead and national team, along with facilitation of National Consultative Forum for Disabilities in developing and completing a 3-year work programme. |  |
• **Emergency departments** - the team works with the national programme lead and colleagues in regard to quality analyses

**Service Level Agreements**
We work through SLAs in collaboration with TCD on a number of pieces of work – the 3 key projects now in the planning stage for 2012 are:

- Development of a Summer School in Implementation Science with input from HSE.
- Analysis of “Growing Up in Ireland” data to determine the obesity trajectory in the 9 year old cohort, now age 13.
- Design and implementation of an intervention to address obesity in young teenagers using ICT/social media.

The Cystic Fibrosis Registry (Ireland) runs a register of patients in Ireland with CF and records the care they receive and their outcomes. This provision of the registry is funded by the HSE and overseen by HI. Collaborative work on development of the register is continuing.

**EUROCAT**

Health Intelligence provides surveillance of congenital malformations through its three congenital anomaly registries in the East, Southeast and South, covering 62% of the births nationally. The registries are members of the European network of similar registries, EUROCAT, which is working in a Joint Action with the European Union from 2011-2013. The registries are undertaking a national study in 2012 on the incidence of Neural Tube Defects with the national clinical leads in Obstetrics and Paediatrics to inform deliberations of the Food Safety Authority of Ireland on the need for mandatory folic acid fortification of staple foodstuffs.

**Health & Patient Information**

**Key work underway includes:** Development of a framework for self management with particular reference to long term conditions. The objective is to empower patients, improve self efficacy and health outcomes.

HIQA GP referrals Report- Currently assessing the progress made by all hospitals in implementing the recommendations. The objective is to improve access to outpatients and diagnostics and improve patient safety.

**Integrated Incident and Risk Management**

**The primary role of the National Incident Management Team is:**

- To ensure that those affected by incidents are cared for and supported and that sources of harm are addressed immediately to prevent further harm
- to ensure that we learn from failures in provision of care or service and,
- through learning increase safety for service users
- through learning contribute to optimal planning and delivery of service

The team members are drawn from acute and primary care services and from national directorates such as HR, Ambulance Services, Legal and Finance. We also have links with the Regional Managers for Consumer Affairs and...
Quality and Patient Safety Managers and key stakeholders across the health service.
If you would like more information about any of our work detailed below, please contact us.

**Central Office, National Incident Management Team** is responsible for the support and administration of:

- Receipt of cases escalated to NIMT
- Processing of cases for NIMT meetings
- Supporting NIMT liaison with DoH, HSE senior management, and the risk committee
- Supporting NIMT liaison with external agencies including indemnifiers and professional and other regulators

Supporting NIMT engagement with regional services and all directorates

**Risk Management**

The Directorate lead role for Risk Management includes:

- Support ongoing implementation of HSE integrated risk management policy
- Ensuring all risk management documentation, policy and guidance and tools are kept up to date
- Provision of risk management training and facilitation
- Administration and monitoring of the HSE Corporate Risk Register - this involves working with National Directors and others to ensure risk assessments are completed and action plans reviewed and monitored.
- Provision of risk register reports to National Director QPS, PMCC, HSE Management Team, HSE Risk Committee, HSE Board

Provision of quality and risk management advice, expertise and support for various projects and work streams e.g. Corporate Plan Development, Service Planning, implementation of Recommendations from reports, patient safety issues etc.

**Assurance on Incident Management within the HSE**

It is the role of the NIMT to assure the HSE management team of high quality within the organisation of incident management. We do this by:

- Audit of incidents whether escalated to the NIMT or not. We look at issues such as the terms of reference of investigations, involvement of the affected service user, the correct use of systems analysis, use of HSE policy on incident management, engagement of appropriate external experts in completing the work. We report this work to the relevant national directors
- Oversight of cases
- Direct engagement with national directorates and with service providers

**Directly Managed Cases** - A small number of cases are directly managed by the NIMT. Usually this is because the issue is very substantial, or crosses multiple geographic or specialty boundaries, or is national in scope. Recent examples include:

- The DePuy Hip Recall
- The Miscarriage Misdiagnosis Incident
- The failed transfer of a service user for Liver Transplant

**NIMT oversight of Cases** - More frequently NIMT oversees local or regional management of a case. NIMT provides expert advice to local or regional management in areas such as:

- Appropriate scope / terms of reference
- Appropriate use of external expertise
- Comprehensive investigation using systems analysis
- Communications advice
• Interaction with other processes
• Involvement of regulators
• Referral to outside agencies

Indemnity arrangements for incident management and investigation

**Examples of Cases** - There are many different types of incidents. At the centre of them usually is the possibility that failure in care or service provision caused harm to a service user, staff, and the public. It is the role of Incident Management to:

• Openly disclose harm
• Establish what happened and why it happened
• Support, care for and involve those affected including sharing the findings of investigations with all who were affected
• Recommend change to reduce future risk and enhance quality and safety

Examples include breaches of confidentiality, issues with diagnosis, and failures in medical devices. Approximately 80,000 incidents are reported nationally each year

**Escalation to our National Team** - Most Incidents are managed locally through the processes NIMT audits. We have certain criteria we use for escalation to our team. These include:

• Where an incident crosses boundaries (geographic or other)
• Where a locality lacks capacity to manage
• Where external expertise is required
• Where a look back review is required
• Where an issue of competence or professional performance is involved
• Where public confidence could be damaged
• Other reason at discretion of the locality or NIMT

**Research** - Work is continually underway to critically analyse Incident Management. We are working with the Aviation Research Psychology Programme in TCD on an Investigation Process project to standardise investigation methods as much as possible across numerous investigative procedures and to describe the linkages between elements that can not be standardised. The purpose is to enhance investigation productivity and efficiency, remove duplications, prevent omissions and describe linkages so that necessarily different investigations do not jeopardise each other.

We are currently working in collaboration with others in the areas of human factors in incident management, and the prevalence of incidents in the Irish healthcare system

**Service User Involvement in Incident Management** - Service User advocacy is represented on our team. We routinely include service users or advocates on teams managing our directly managed cases. We are working to further integrate in the areas of Incident Management, Risk Management and Complaints and in 2012 are delivering integrated training in these areas

**Future Directions in Incident Management** - Within the reformed health services there will be roles for national incident management and we are working with the DoH and other stakeholders to “future proof” the work of the NIMT. We are developing enhanced ICT support for Incident Management in Ireland, the first phase of which went live in February 2012.

We are updating and enhancing our incident investigation and management processes to:
− Enhance incident reporting rates so that we can better identify opportunities for safety improvement
− Enhance investigation methods to better find problems causes and solutions
− Enhance how we involve, support, care for and disclose openly and fully to - all involved and affected
- Reduce cost and legal complications
- Complete investigations and implement learning for safety improvement in a more timely manner

**Learning** - Without learning from Incidents there is little purpose to Incident Management. Most learning is local (as most incident management is local). Generalisation of learning is achieved through the following mechanisms:

- Building a culture of patient safety which promotes and supports incident reporting, investigation and management
- Enhancing investigation methods to find actual problem causes and actual generalisable solutions
- Population of Risk Registers with outputs of Incident Management processes
- Publication of Reports of Incident Investigations
- Publication of aggregate incident statistics
- Issuance of learning notices
- Learning events (held nationally and regionally)

Empowerment of service users and of healthcare provider staff

## Quality and Patient Safety Audit Services

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| Quality and Patient Safety Audit (QPSA) promotes the delivery of quality, safe, accessible, and sustainable health, personal and social services by providing internal independent assurance. It forms a key part of the HSE’s overall Assurance Framework and is part of the Quality and Patient Safety Directorate. | **Edwina Dunne**  
Director of Quality and Patient Safety Audit  
Ph: 01 6352389  
E-mail [edwina.dunne@hse.ie](mailto:edwina.dunne@hse.ie)  
and/or  
**Suzanne Kirwan**  
Ph: 01-6201822  
Email: [suzanne.kirwan@hse.ie](mailto:suzanne.kirwan@hse.ie)  
**Deborah Kavanagh,**  
P.A. to the Director of QPSA  
Ph: 01 6352389  
Email: [Deborah.kavanagh@hse.ie](mailto:Deborah.kavanagh@hse.ie) |

The primary role of Quality and Patient Safety Audit is to:

- conduct audits and re-audits to assess the level of compliance with standards, procedures and guidelines, and make recommendations to achieve the required standard.
- provide internal independent assurance within the defined responsibility of the National Director of Quality and Patient Safety.
- play a key role in driving the quality improvement agenda through promoting accountability for quality patient safety as part of the overall Quality and Patient Safety Directorate (QPSD), QPSA.
- complete the Assurance Framework by filling the assurance gap for clinical and social services (Level 2).
- complement and augment the existing Level 1 (Quality & Risk self Assessment) and Level 3 (Internal Audit) functions within the HSE.
- provide audit recommendations that will be used as an integral part of performance analysis and trending, as the QPS national monitoring and learning function is developed.

There are fifteen auditors in our team; they are variously located around the country.