



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

Quality Improvement Division Annual Report 2016

Tús Áite do
Shábháilteacht 1 Othar
Patient Safety 1 First

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Introduction

This report provides a high level overview of work completed by the Quality Improvement Division (QID) in 2016.

In 2016 QID focussed on developing and articulating the Framework for Improving Quality that linked together the Areas of work in Quality Improvement (QI) that were evolving based on best evidence; continued its work in the areas of key safety programmes, service support for QI, and Global Health.

Who we are

The Quality Improvement Division was established in 2015 to support the development of a culture that ensures improvement of quality of care is at the heart of all services that the HSE delivers.

Our mission

To work in partnership with patients, families and all who work in the health system to innovate and improve the quality and safety of our care.

Role and function

Our role is to champion, educate and build capacity for quality improvement and demonstrate new ideas and approaches to quality improvement.

Framework for Improving Quality

The Framework for Improving Quality was developed with the aim of creating an environment in which a culture of person-centred quality of care continuously improves. To this end, in 2016, the *Framework for Improving Quality in our Health Service Part 1: Introducing the Framework* document was published.

Part 1 of the '*Framework for Improving Quality in our Health Service*' resource introduces the Framework and the six critical success factors (Drivers) for delivering and supporting continuous quality improvement. It is the combination of these six drivers working together that creates the environment and acceleration for improvement.

The six drivers for Improving Quality are:

1. Leadership for Quality.
2. Person and Family Engagement.
3. Staff Engagement.
4. Use of Improvement Methods.
5. Measurement for Improvement.
6. Governance for Quality.

The Framework for Improving Quality is a high level framework that requires application at organisational level and with frontline teams to provide the necessary detail of how each driver translates into useful actions to inform, support and guide organisations to foster a culture of quality care that continuously seeks to improve.

To this end the Quality Improvement Division is partnering with a number of organisations to learn from the application of the framework and use this experience to demonstrate how the framework can be applied and prepare part 2 of the '*Framework for Improving Quality*' resource for others to use.

To support this programme of work QID has established Partner Teams to support each site in the application of the Framework. Partner Teams comprise of QID staff to provide coaching, support, guidance and facilitation in improving quality within each of the demonstration sites.

Members of the Partner teams have a range of relevant knowledge and competencies, and several have frontline experience as nurses, managers and quality improvement.

The overall programme of work is divided into three phases over four years with an expected completion date for all phases by December 2020.

Phase 1: is now completed with the publication of the Framework for Improving Quality.

Phase 2: Partner with 3 demonstration sites to apply and translate the framework into useful actions to guide their quality improvement work and share the learning from this translation across the remaining services by December 2017.

Phase 3: Share the learning from this translation of the Framework.

Leadership

Diploma in Leadership for Quality Improvement

It is recognised that to build a culture of improvement in any large organisation that building a critical mass of leaders with expertise in quality improvement is an essential critical success factor. To build this capacity the diploma in leadership for quality improvement was developed in collaboration with the professional colleges. In 2016, the diploma has seen 120 graduates from cohorts 8, 9, 10 and 11 consisting of staff from a broad range of senior clinical and management across the HSE. This has heightened awareness of quality in leadership teams and senior management across all services and demonstrates HSE commitment to developing leadership and knowledge in QI and management teams have senior staff and clinicians that understand the importance of quality and have training to support their organisations/services deliver on QI initiatives.

Clinical Director Programme

The Clinical Director Programme supports the role of the Clinical Director (CD) and also the development of the Clinical Directorate model.

In 2016, site visits and interviews with Clinical Directors and multidisciplinary clinical directorate staff were carried out on numerous sites to ascertain CDs experiences in undertaking clinical leadership roles in the various operating models which differ from site to site. All knowledge gained has been used to highlight salient issues and challenges at national level in progressing clinical leadership in the Irish healthcare. This is primarily achieved by using appropriate platforms namely the Joint HSE/Forum of Irish Postgraduate Training Bodies Group, the Chief CD Forum and meetings with relevant National Directors to highlight issues and concerns of the Clinical Directors and Executive Clinical Directors and to advocate for support and infrastructure to facilitate the CD in their role and the Clinical Directorate Team to deliver safe clinical care.



Participants in the Clinical Directorate Team Leadership Development Programme; Women & Children's CD Team and Peri-operative CD Team, Saolta Hospital Group

This year a review of education and training provided by the CD Programme was undertaken and three distinct approaches identified:

CD Workshops and Masterclasses: provide opportunities for CDs, Executive Clinical Directors in Mental Health Services and on occasion Lead NCHD to meet and network with colleagues. Workshops were held in January, masterclasses in March, April and May including topics like building personal and team resilience (Gail Neilson) and Frontline Ownership (Dr. Michael Gardam and Leah Gitterman).

Clinical Directorate Team Leadership Development: Three Future Leaders Programmes secured from HR and tailored to meet the needs of the Clinical Directors and their multidisciplinary Clinical Directorate teams. CD Team Leadership development programmes commenced in Saolta Hospital Group in Sept/Oct and two further programmes are planned for implementation in South/South West Hospital Group in January 2017 and University Limerick Hospital Group in May 2017.

Clinical Director Training: funding secured from QID to procure a provider to design and deliver an education programme for a cohort of Clinical Directors and Consultants aspiring to commence in clinical leadership role which is envisaged will commence in Quarter 2/3 2017.

Person and Family Engagement

International studies shows that bringing the perspectives of patients, service users and families directly into the planning, delivery and evaluation of health care and working in partnership with patients and families improves the quality and safety of health care and patient and staff experience, while also demonstrating the organisations commitment to person centered care.

Person centeredness is a key component of delivering quality care and is one of the domains of quality as set out in the National Standards for Safer Better Healthcare. Person and Family Engagement has been also been recognised as a key driver in the 'Framework for Improving Quality in our Health Services'.

QID undertake a number of programmes to ensure person and family centeredness are integral to the health service design and delivery as follows:

- National Patient Forum.
- Patients for Patients Safety Ireland (PFPSI).
- Listening sessions.
- Networking Group for Patient Liaison Staff and Quality Managers.
- 'What Matters to You?'
- Patient Councils.
- 'Hello my name is'

National Patient Forum

The National Patient Forum is a patient participation group comprising of 52 active members of patients, family members, carers, representatives of advocacy groups, disability organisations and members of Patients for Patient Safety Ireland (PFPSI).

The National Patient Forum has become the first point of reference for HSE national divisions and programmes when seeking a patient input into national policy and programme development. It provides an effective mechanism for co-ordinating the patient's input, which facilitates efficient planning of services to meet patient needs and priorities.

The Quality Improvement Division is instrumental in facilitating engagement between the HSE and the National Patient Forum.

Work undertaken by the National Patient Forum and its members in 2016 include:

- Primary Care, Assisted Decision Making (ADM), HIQA service user panel, and Policies, Procedures, Protocols and Guidelines.
- Participation in national consultation processes namely: Focus group on Outpatients Services, Draft National Framework for Self Management Support for Chronic Disease, National standards for the prevention and control of Healthcare Associated Infections standards, GP services, Nursing & Midwifery Quality-Care Metrics, Individual Health Identifiers.
- Four members of the Forum submitted abstracts to the International Conference on Integrated Care Dublin 2017.
- Four of the patient organisations represented at the Forum are working with Health & Wellbeing to develop a pilot exercise programme for patients with chronic diseases.

Patients for Patients Safety Ireland (PFPSI)

Patients for Patient Safety Ireland (PFPSI) is a part of the World Health Organisation initiative aimed at improving patient safety in health care. The Patients for Patient Safety network has over 250 members spread across 52 countries. The purpose of the network is to promote understanding and dialogue around patient safety, foster collaboration and build links between patients and staff on the range of patient safety efforts, so that lessons can be shared and partnerships created.

PFPSI was established in 2013 and comprises of people who experienced serious harm or death of a loved one in the Irish health care system, as well as healthcare staff. Members of PFPSI are committed to using their unique experiences to inform healthcare improvement and the prevention of adverse events. They do this in collaboration with healthcare staff at all levels through education, research, regulation, policy making and especially by telling their personal stories and presenting at conferences, workshops and training events.

Key activities included:

- Involvement in the roll-out of the National Policy on Open Disclosure .
- PFPSI poster was displayed at the Integrated Care Conference in October 2016 and the Patient Safety Conference in December 2016.
- Two members of PFPSI joined the Quality Improvement Division management team as patient representative members.

- Six patient stories were recorded by PFPSI members in 2016. In these stories patients for patient safety share their experiences of healthcare, adverse events and personal tragedies. It is envisaged that these stories will be used for learning and promoting the patient safety agenda. The stories will be made available online to healthcare staff and will form part of the PFPSI website.

Listening sessions

Listening to the patients' perspectives on their experiences of health services is critical to gaining an insight into patients' needs and priorities and identifying what is working well and what needs to improve.

Further to the collaboration with Age Friendly Ireland on the first round of the listening sessions with older people which took place in 2014 and the publication of the report in 2015, a second round of listening sessions took place in November 2015. The listening sessions were held with representatives of older people's councils in Cork, Dun Laoghaire, Letterkenny, Limerick and Roscommon. The report on these listening sessions was published in 2016 and includes feedback received from older people in each area, as well as responses received from health service providers.

Common themes across all geographical areas were identified in the report, as well as issues that are area specific. One of the most common themes in the report is the need for more community supports to help older people stay in their homes for as long as possible.

Networking Group for Patient Liaison Staff and Quality Managers

A networking group for staff working in quality and patient liaison roles in acute hospitals was established to provide a forum for learning and sharing experiences on patient engagement and promoting person centred care. Work of the group will continue in 2017, with more networking events planned, including learning from international colleagues.

'What Matters to You?'

'What Matters to You' has been introduced successfully in a number of countries and in different settings. In 2016, we drew on the experiences of our colleagues in NHS Scotland, to partner with the National Clinical Programme for Older People on the introduction of the 'What Matters to You' initiative in two acute hospitals.

‘What Matters to You’ focuses staff attention on the person, rather than just a patient or their condition, helps them to have more meaningful interactions with patients and ultimately to provide care that is more person centred in its approach. Information gained from ‘What Matters to You’ story boards can be used in shared decision making and to make patients feel like active partners in their care.

Engagement with the two participating hospitals will continue in 2017 and will include post implementation evaluation and sharing of learning with other hospitals.

Patient Councils

At service delivery level participation of patients and family members on patient forums and councils is one of the models of joint, collaborative working and partnership. The Quality Improvement Division promotes this model of patient engagement by providing advice and support to hospitals regarding how to engage with patients and develop patient councils.

In addition to making guidance available online, we provided support and advice to the following individual hospitals and hospital groups and their patient councils: Saolta Hospital Group, University of Limerick Hospital Group, Naas General Hospital and Letterkenny General Hospital.

‘Hello my name is’

The Quality Improvement Division provided guidance and support on the roll-out of ‘Hello my name is’ in acute hospitals and community healthcare organisations, including developing a checklist for implementation and making it available online and engaging with individual organisations.

Open Disclosure

Driving and supporting the implementation of the Open Disclosure (OD) policy across hospital groups, CHOs and NAS:

Training Programme:

- Train the Trainer Programme: x 8 two day programmes delivered and 115 further staff trained as trainers. There are now open disclosure trainers in all hospital groups, CHOs and NAS.
- All training logged on a national database and reports provided - maintenance of database is ongoing.

- 12,716 staff have attended briefing /workshops on OD - total to date. Workshops delivered to staff in the Office of the Ombudsman and to National QPS staff.
- Presentations delivered to nursing, midwifery, medical and quality and risk students in TCD, UCD and UL and to programme coordinators in TCD.
- Training provided to radiology students.
- All colleges and universities contacted to establish current status re OD training as part of medical, nursing and midwifery and AHP undergraduate and post graduate programmes.
- Provision of ongoing support and guidance for trainers.

Further developments include:

- Identification of OD leads for CHOs, Hospital Groups and NAS and of site leads in hospital sites: site leads identified in 35 acute hospitals.
- Development of significant resources and further development of open disclosure web page - all training materials available on: www.hse.ie/opensdisclosure
- Hand over to Services: Agreement and sign off by HSE leadership for the hand-over of responsibility for the further implementation of the national open disclosure policy to the CHOs, hospital groups and NAS - effective from 31st December 2016.
- Completion of Independent Evaluation of OD Pilot Programme: Completion and circulation of the report of the independent evaluation of the national open disclosure pilot project.
- Conferences: (i) Presentation of project at the World Health Congress on Clinical Safety in Harvard Medical School, Boston in September 2016. (ii) OD Conference in Letterkenny University Hospital in October 2016.

Staff Engagement

Staff Engagement is a key driver of the Framework for Improving Quality in our Health Service - the importance of this work was not only highlighted in the Your Opinion Counts Survey results 2016 but the benefits have been demonstrated extensively in international literature and research.

National Staff Engagement Forum: #engaginghealthstaff



In June 2016, the HSE QID and HR Divisions established the National Staff Engagement Forum. It is the vision of members that the Forum will become a space for staff to bring their thoughts and ideas about how we can engage with each other more fully in our health service and directly influence and shape how we involve all staff in the design and delivery of services.

The Forum is designed to have a proportional representation of staff which reflects the current staff profile in the health service as shown in the 2015 Health Service Personnel Census.

In total, there are 50 staff members from across health and social care services and there are a number of members from a strategic engagement leadership group committed to driving the change agenda.

Schwartz Rounds: #SchwartzIreland

Schwartz Rounds provide a framework which has been proven to improve staff wellbeing, resilience and teamwork which ultimately has an impact on improved person centred care.

In 2015, the Quality Improvement Division engaged the Point of Care Foundation to licence, train and mentor staff in the Blackrock Hospice and the Galway University Hospital to test the introduction of Schwartz Rounds in an Irish context. Eight staff members were trained in 2015/2016 and commenced the test of concept in 2016 facilitating rounds on each site. Teams presented their work at several national conferences including the National Patient Safety Conference and won a prize for the photo competition at the Manchester Schwartz Conference.

Schwartz Rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work. The structured, monthly meetings provide an opportunity to have lunch together and share stories of our experiences. Each round is based on the story of a particular patient, or a theme and is briefly presented by two or three members of staff involved in the care of the patient. This is followed by a facilitated discussion which involves the wider audience and is an opportunity to share, support and listen.



Clinical Microsystems:

Clinical Microsystems is a quality improvement approach which originated from Dartmouth Institute, USA. It has been used widely across the USA and has been adopted more recently in Ireland in the Emergency Department setting. A microsystem is a small frontline unit which is only one within the larger organisation and is the place where patient, families and carers meet. Each unit can change over time and has a patient at their centre. Each microsystem should be encouraged to find ways to improve and innovate on a day-to-day basis.

In 2013, a training programme in Clinical Microsystems was provided in Ireland with 2 cohorts of staff over 2 year period. Since September 2016 this approach is being supported by Staff Engagement Unit of QID with the Emergency Medicine Programme. The plan is to re-engage frontline staff in Emergency Departments across the country to utilise this approach as a way to improve care for both patients and staff. This is a very pragmatic and intuitive approach and typically is adopted initially within one department and then spread within the organisation.

Staff Listening Sessions: #stafflistening

Listening sessions provide an opportunity for staff to share their experiences and ideas on how to improve their service. The sessions also create a platform for staff to work with Senior Managers to review and act on the top suggestions. Learning from this process is being evaluated at present to develop guidance and training for leaders who wish to engage with staff on improving quality.

In 2016, listening sessions were held in acute, mental health and primary care settings.

Front Line Ownership: #FLOIreland

From October 2015 and June 2016, QID facilitated a test of concept for a Front Line Ownership (FLO) in University Hospital Kerry, capacity building and the development of QI coaches with Ignite Consulting, international experts in this area.

FLO encourages staff to creatively develop solutions to challenges they face daily.

The work with Kerry has involved in excess of 50 staff working on 5 teams *Communication, Culture, Flexible Working, Waste and Training and Education*. The themes came from staff feedback and suggestions in the staff listening sessions.

There have been three on-site visits with regular coaching calls.

Workshops have also been organised for the HSE Leadership Team, senior managers, clinical directors and staff to spread the message about front line ownership and the benefits of working with staff to find solutions to challenges.

Posters were developed and shared at the National Patient Safety Conference and the Integrated Care Conference In 2017. A liberating structures user group is planned and the FLO principles will be incorporated into future training programmes for leaders.



Lead NCHD Programme

In 2016, the Staff Engagement programme engaged with the National Lead NCHD Programme to understand the challenges faced by NCHDs through an informal listening session and with the Lead NCHDs to further develop their skills for engagement for quality improvement. Work is ongoing in collaboration with Dr. Mortimer O'Connor, Lead NCHD and colleagues in the Mercy University Hospital in a new programme which uses a staff listening and front line ownership approach to support NCHDs to identify and act on ideas. The focus of this work will be NCHD wellbeing.

The Assisted Decision Making Programme

The National Assisted Decision Making Programme was established in the QID in 2016 to co-ordinate and facilitate the HSE system-wide response to and preparation for the commencement of the Assisted Decision Making (Capacity) Act 2015. Key milestones in 2016 include:

- A **National conference** in Croke Park with 500 attendees and over 1,200 via webcast.
- The establishment of the **Assisted Decision Making Steering Group**, chaired by Professor Deirdre Madden, with representatives from the HSE Divisions, Service Users, Clinical and Subject Matter Experts.
- The establishment of a number of working groups as follows:
 - ◇ **Guidance and Documentation Working Group** who have developed a **Draft Guide** on the Act document for consultation.
 - ◇ **Training and Education Working Group** who have developed a **Draft Training and Education Programme** on the Act.
 - ◇ **Information and Communications Working Group** who developed the website: www.assisteddecisionmaking.ie.
 - ◇ **Divisional Leads Working Group** which includes **eight divisional leads** tasked with implementing the Act across **mental health, health and well-being, disability and older persons services, primary care, the national ambulance service, national finance and the Acute Hospital Programme**.

- An **Advance Healthcare Directives Multidisciplinary Working Group** has been established by the Minister for Health and managed by the HSE to draft the **Codes of Practice on Advance Healthcare Directives** for consideration by the Director of the Decision Support Service.
- **Impact Assessments and Information Sessions** have been taking place around the country on the Act, over 220 people have been consulted in 2016 in primary care, disability services, older persons services, Acute Hospital Services, National Ambulance Service and health and well-being.
- Ongoing links have been developed with key **Government departments, agencies and stakeholders** central to the implementation of the Act, including the Department of Health, Department of Justice, HIQA, NDA, Mental Health Commission.
- Two members of the HSE ADM Programme are members of the **NDA Technical Experts Group** for the development of the ADM Codes of Practice.

Use of Improvement Methods

QI Talktime

The Quality Improvement Division (QID) trialled a webinar series called **'QITalktime'** which focuses on Quality Improvement in Q3 and Q4 2016. The webinars were open to all staff interested in improving Quality across our Health and Social care services and will help to:

- Connect with others interested in Quality Improvement
- Share learning and experiences of service redesign and improvement

The series of planned webinars began with a number of trial webinars from June 2017:

Date	Speaker	Topic	Participants
June	Prof. Lloyd Provost	Measurement for improvement	62
August	Prof. Brendan McCormack	Developing a culture of person centeredness	68
October	Mary McKenna	STOP: Care bundle implementation	45

Following the success of the trial webinars QI Talktime initiative was formalised.

Training Skills in Quality Improvement

The course was a 'train-the-trainer' type programme that provided participants with comprehensive knowledge on how to design, develop and deliver training and facilitation. The course saw 2 cohorts of 24 staff in total complete this programme. The course covered learning objectives, learning styles, managing groups and evaluating training. It also provided key tips, tools and techniques for facilitating and delivering training. Participants have now been trained to:

- Design learning objectives for a training intervention or facilitation session.
- Develop a training intervention or facilitation session.
- Deliver effective training using current techniques and tools.
- Evaluate training against learning objectives.

Coaching Skills in Quality Improvement

This course provided participants with comprehensive knowledge on, contracting for how we work together, elements of a coaching conversation, emotional intelligence, self awareness and self management, style of conversations, adult to adult conversations using transactional analysis and working styles. The course saw 2 cohorts of 24 staff in total complete this programme.

Lloyd Provost Week – National Quality Improvement Programme

During the week of the 13th June Lloyd Provost delivered the following workshops:

- Profound Knowledge for the Frontline.
- Advanced Data for Improvement.
- Driving Better Decisions.
- Measurement for Leaders and New Perspectives – Spread and Scale Up.
- QID Webinar – Data for Improvement.

Measurement for Improvement

The Measurement for Improvement team (MIT) combines expertise in the science of quality improvement, statistical analytics and qualitative research with clinical expertise. We work in partnership with Health and Social Care Services. Our mission is to educate and enable people to collect, interpret and contextualise data, to evaluate and drive improvements in quality of care. Our vision is that quality of care is improved by the routine use of the right information, being measured in the right way to make better decisions.

National Quality Profile

A Proof of Concept National Quality was developed and presented to the HSE Leadership Team in December 2016 following consultation with key stakeholders. In addition a test of automating the production of Statistical Process Control (SPC) charts for the National Quality Profile was successfully completed with the Office of the Chief Information Officer.

Social Care, National Division, Quality Profile

In a partnership project with the Social Care Division, the Quality Profile continues to develop and now includes SPC. Charts to explain the role of variation in data collected for a number of measures that are important to social care service users e.g. Compliance with HIQA standards and Pressure Ulcer incidence.

Temple Street Board, Quality Dashboard

In partnership with Temple Street, the Temple Street Board of Directors review quality of clinical care indicators presented in SPC charts at monthly board meetings.

The first National Sepsis Report was published in December 2016 based on data analysis provided by the Measurement for Improvement Team.

Development of Measurement for Improvement Tools

A collection of online resources were developed and launched on the MIT webpage throughout 2016.

The resources include introduction to measurement for improvement and key concepts, guidance on designing, administering and analysing surveys, guidance on conducting qualitative evaluation and research including designing research questions, qualitative methods and analysis, checklist to prioritise measures of quality of care, guidance and tools to create and interpret SPC charts, template to develop measurement plan, sample driver diagrams and a range of resources to create a quality profile. In addition, MIT presentations and publications of interest are available.

MIT Curriculum

The draft Measurement for Improvement Curriculum was completed and sent for international expert review. The curriculum identifies the needs of those engaged in measurement for improvement work. It identifies key content areas, tasks and required knowledge for measurement for improvement practitioners at five increasing levels from entry level to expert. It will be used as the basis to deliver training focused on the measurement driver in the Framework for Improving Quality in Our Health Service.

Tweeting 'Measurement for Improvement'

Quality improvement and measurement for improvement were promoted through the use of twitter accounts for members of the Measurement for Improvement Team, and through the use of QID hash tag #HSEQIConnect which generated over 300,000 twitter impressions and over 500 tweets between May and December 2016.

Consultancy and Advice

During 2016, MIT provided analysis and expert advice to a wide range of groups looking to understand and/or improve the quality of their services. Groups include: Pressure Ulcer Collaborative, Medication Safety Programme, SDQ/QID QI programme, Person and Family Engagement programme, Specialty Quality Improvement Programmes, National Office of Clinical Audit and St. Vincent's University Hospital. Projects include: Paediatric Early Warning Score Programme, Health Care Associated Infections, Out of Hours Primary Care Service, Schwartz Rounds, Mental Health Incident Report Analysis, Primary Care and other service patient experience measures, Nursing Metrics and Patient Safety Statements.

Governance for Quality

The Governance for Quality team aims to provide quality improvement support to frontline services (or divisions working with the frontline) and advice across the key components of effective governance for quality in healthcare services.

Governance for Quality Achievements for 2016

Demonstrate: Quality and Safety Walk-rounds Publication

- Updated guidance, new toolkit and case study report co-designed with Beaumont Hospital.
- ‘*Launch and Learn*’ event shared experience with 90 leaders from across health services.

Champion: Quality and Safety Committees

- National guidance and resources expanded (following consultation during 2016), endorsed by the HSE leadership team and disseminated in October 2016.
- Support provided to the Primary Care Division and independent chair in the establishment and quarterly meeting of the *National Primary Care Quality and Safety Committee*.
- Support provided to the Social Care Division in the review of Terms of Reference and membership of the *Social Care Division Quality and Safety Committee*.
- Support provided to the National Ambulance Service in the development of national and area terms of reference for *Quality and Safety Committees*.

Partner: Board on board Projects

- Commenced Saolta University Healthcare Group and the Children’s University Hospital Temple Street board projects (with QID Measurement for Improvement Team).
- Developed a new resource for executive and non-executive members of boards ‘*A Board’s Role for Improving Quality*’.



Quality and Safety Walk-rounds Launch and Learn Event 6th June 2016

**Front Row: Philip Crowley, National Director QID and Liam Duffy, CEO Beaumont Hospital.
Back Row: Karen Greene, Petrina Donnelly, Kate Costello, Prof. Edmond Smyth, Barbara Keogh, Dr. Fidelma Fitzpatrick and Maureen Flynn.**

Educate

- Facilitation of monthly *Learning Set* for acute hospitals attended by nominated quality and safety staff.
- Education sessions provided for undergraduate and post graduate education students on the Framework for Improving Quality in Our Health Service and Governance for Quality.
- Publication of monthly *Quality and Safety Column* in the *World of Irish Nursing* and Midwifery.
- Participation with *Service Improvement Programme* – development of CHO design principles.
- Membership of Social Care Division Leadership and Governance Sub-group developing governance resources tailored for intellectual disability services.
- Facilitation of the QID Service Planning Process.
- Managed twelve projects providing advice and support to various services within the health system.

National Safety Programmes

Decontamination Safety Programme

Endoscope Decontamination Acute Service

Disseminated a “Guidance Note for the Management of Endoscopes Used Out of Hours for Unplanned Emergency Procedures” to all Group Hospital CEO’s.

Ultrasound Probe Decontamination: Acute Services: The Decontamination Safety Programme circulated a draft “Guidance Document for Decontamination of Semi-critical Ultrasound Probes” (December 2016) for consultation, final publication due in January 2017.

Transport of Used Medical Devices: Acute and primary Care: Developed a guidance document to support safe transport of uncleaned RIMDs in Acute and Primary Care.

Loaning and Borrowing: Acute services: Supported the update of the Voluntary Healthcare Agencies Risk Management Forum, “Medical Device Loaning, Borrowing and Trialling” Document which has been adopted in its entirety by HSE.

Primary care Decontamination: Published “Guidance for the Application of Standards and Recommended Practices for Local Decontamination Units in Primary Care GP, Podiatry and Dental Practice”.

Access to Standards: Provision made for all HSE hospitals with online access to 50 European Standards applicable to medical device management and medical device decontamination. This is the first National Healthcare project of its kind in Europe, providing savings of €500,000.

Sharing Learning: Utilisation of the Medical Device e-alert system to disseminate and share learning from decontamination incidents (National and International) to service providers.

Academic Programmes: In partnership with IT Tallaght and Industry, the Quality Improvement Division’s Decontamination Safety Programme supported the development of a blended learning Level 6 Minor Award in Endoscope and in Surgical Instrument Decontamination (September 2016). In total the QID have funded 45 students, with a further 45 students funded by their local hospital. Both the Endoscope and Surgical Instrument Minor awards will continue to run indefinitely, with the next intake of students planned for September 2017.

The National Decontamination Advisory Group (NDAG): The NDAG and QID Decontamination Safety Programme partners include, stakeholders who participate in the decontamination standards review group, the Irish Decontamination Institute (IDI), Institute of Healthcare and Estates Managers(IHEEM), Institute of Decontamination Science (IDSc) UK, Institute of Technology Tallaght, Industry Partners, Healthcare Products Regulatory Authority(HPRA), National Standards Authority of Ireland (NSAI), Irish Society of Endoscopy Nurses, Dental Inspectorate, Joint Advisory Group (JAG) on GI Endoscopy etc.

Collaboration: The collaboration between the QID, Medical Device Equipment Management Committee, Fingerprint Medical, the National Tracking and Trace Implementation Group and stakeholders has supported the national implementation of a unique electronic system to track the decontamination of RIMD and trace them to the patient on whom they are used.

Project implementation commenced 2011, full roll out is expected by December 2017- work in progress on schedule.

National Procurement: National Procurement Portfolio for Decontamination equipment has been developed and a National Framework for procurement of equipment.

ISO 13485: Our Lady's Hospital, Navan

The National Decontamination Lead with kind agreement from the CEO of Temple Street Hospital, Ms Mona Baker, has taken the quality system and translated the system into the context of the Decontamination Unit in Our Lady's Hospital Navan. This test of change has taken 9 months of hard work and commitment by the Decontamination Unit Manager Ms. Dympna Fegan with Governance and Leadership Team support from the Group Hospital CEO and Navan Hospital GM. Final audit by the National Standards Authority of Ireland in Navan Hospital Decontamination Unit is planned February 2016.

All supporting documents cited in this end of year report are available for review on the Quality Improvement Division's Webpage:

www.hse.ie/eng/about/Who/qualityandpatientsafety/Medicaldevices

Medication Safety Programme

Ireland is uniquely poised to reduce the potential for patient harm from medicines or their omission. We have exemplars of best practice throughout the country, dedicated professionals focussed on medication safety, a wealth of high-quality research and a will to collaborate and improve.

The National Medication Safety Programme, “**Safermeds**”, is one of the priority safety programmes within the HSE Quality Improvement Division. Using the HSE framework for improving quality, we will work with patients, healthcare professionals and organisations to **reduce patient harm associated with medicines or their omission**.

We will build on the excellent work already taking place locally to bring about greater improvement and reduced variation. Medication harm is frequently estimated as causing somewhere in the region of 20% of all harm to patients.

The 3 main projects currently underway are:

Preventing Venous Thromboembolism (Blood Clots) – Improvement Collaborative with Adult Acute and Maternity Hospitals – 31 Hospitals are participating and instituting changes to VTE assessment and prophylaxis. Hospital – acquired VTE can lead to death or serious harm and result in patients needing therapeutic anticoagulation, bringing risks of bleeding, inconvenience and cost.

Assessing in-patients for VTE and bleeding risk and choosing appropriate prophylaxis (e.g. antithrombotics +/- compression stocking or none) can greatly reduce patient’s risk of VTE and avoid overtreatment.

The VTE Improvement Collaborative brings together multidisciplinary teams to seek improvement in appropriate prophylaxis. Attending 5 learning sessions over 12 months, action periods between sessions allow team to identify, test and implement changes and measure progress towards improvement.

A standardised template for adult acute care drug chart has been updated. A template of modifiable pages is available on the HSE website. Instead of being a mandated national chart, the standardised template will be available to hospitals, who may choose to use it in its entirety, use some elements but not others, or modify certain elements to meet local needs (e.g. the VTE risk assessment and guidelines would be locally agreed guidelines). It is envisaged that this is a product which can be used locally, and will be shared in a modifiable form.

Support the system in general in their efforts to institute processes to manage medication safely.

QID and the Medication safety Programme funded a training programme, in partnership with The Institute for Safe Medication Practices from the USA, which representatives from all acute hospitals attended. This enhanced their focus and capacity to advance medication safety initiatives in their work places.

HCAI AMR/ ARHAI Clinical Programme

The HCAI AMR clinical programme's overarching principle is that every patient should expect to receive high quality healthcare in a safe environment without acquiring a preventable HCAI or multidrug resistant organism. The programme is working as part of a larger HSE patient safety focus alongside other established safety campaigns.

After reviewing the approaches taken by other countries with respect to HCAI and AMR prevention, the programme's focus on 'getting back to basics' was established. A multidimensional approach must be taken. The aim of the programme is to facilitate healthcare staff focus on key areas every time they care for patients irrespective of the healthcare setting.

These are:

- 1. Use antimicrobials appropriately (antimicrobial stewardship).**
- 2. Hand hygiene as outlined by the World Health Organisations '5 moments'.**
- 3. Prevent medical infections associated with medical devices such as intravenous lines & urinary catheters.**

Antibiotic Stewardship:

Acute Hospital

- Launch of Gent Guidelines and close of Gentamicin collaborative November 2016.
 - ◇ Start Smart then Focus collaborative in RCPI to improve antimicrobial stewardship in acute hospitals ongoing inclusive of 11 acute hospitals. Quality Improvement Education delivered, change ideas tested and measurement plan completed and delivered.

- Developed and implemented antimicrobial audit tool for acute hospitals.
 - ◇ RCPI have adopted this as one of audits accepted for credits.
- Hospital antimicrobial restrictive policy signed off by HCAI AMR National Taskforce and an accompanying governance document completed.

CHO and Primary Care

- New website for www.antibioticprescribing.ie launched end of November 2016.
 - ◇ With new sections such as dental, pregnancy and lactation guidance and antibiotic stewardship policies included.
 - ◇ Competed and updated a website governance policy.
 - ◇ Formed new Antibiotic prescribing editorial board and content advisory groups.
 - ◇ Questionnaire completed in conjunction with ICGP re user views of antibioticprescribing.ie.
- Update of www.undertheweather.ie following review by NALA.
- Ongoing collaboration and data review in conjunction with HPSC and Medicines Management programme on community level antibiotic prescribing data.
 - ◇ New data reporting accessible for community level antibiotic prescribing.
- Antimicrobial stewardship project underway in Out of Hours Centres in South Doc and North Doc.
 - ◇ 8 cells.
 - ◇ Prescriber education materials developed and deployed inclusive of preferred antibiotic mouse pads, posters and antibiotic audit tools.
 - ◇ Patient education materials developed and disseminated inclusive of TVs with specially made video loop and information leaflets.
 - ◇ Measurement plan in place.
- Developed and implemented antimicrobial usage audit tool for GPs.
 - ◇ Education series at numerous ICGP and other events.
 - ◇ Tool available on ICGP website.
- Ongoing ICGP education – elearning programmes, webinars and CME lecture delivery.

System Wide

- European antibiotic awareness campaign Nov 2016.
 - ◇ Communication initiatives – press releases, email broadcast etc
 - ◇ Prescriber education - 6 Webinars for acute and non acute setting delivered and patient education activities for European Antibiotics Awareness Day November 2016

HAI Prevention via Infection Prevention Control (IPC):

Acute Hospital

Line device infections:

- STOP campaign underway to reduce line device infections
 - ◇ Site implementation in Cavan General Hospital inclusive of a number of site visits, webinars, multiple PDSA cycles and ongoing measurement plan
- Project manager recruited for RCSI hospital group

CHO and Primary Care

Hand Hygiene:

- Set up a Hand Hygiene working group to focus on hand hygiene improvement in non acute services.
- Developing a 'How to Guide' for hand hygiene with a focus on non acute setting inclusive of train the trainer programme materials and governance advice for CHOs (Signed off by HCAI AMR Taskforce December 2016).
- Facilitate delivery 'train the trainer' education in non acute services – Pilot of train the trainer materials underway in CHO 9 (November 2016).

Other work areas:

- Toolbox of IPC policies commenced for IPC policies for primary care.
- Involvement in Decontamination/Sterilisation and reprocessing RIMDs in primary care.
- Elearning module for Primary care on IPC/Standard Precautions completed.
- Collaboration with Minor surgery in general practice accreditation research project.
- Collaboration with decontamination safety programme to produce:
 - ◇ Guidance for the application of standards and recommended practices for local decontamination units in primary care GP, Podiatry and Dental Practice.

- ◇ Educational video to provide valuable resource to Prim care services and identify best practice in the design, flow and layout of a Primary Care LDU developed by DDUH applicable to all primary care settings .
- HALT national steering committee for Long Term Care Facilities (LTCF).

System Wide

- WHO hand Hygiene day marked with a communications campaign May 2016.
 - ◇ New Hand Hygiene (HH) video clip to promote technique.
 - ◇ Broadcast email.
- Launched an IPC knowledge and Skills e-learning programme available on www.hseland.ie May 2016.
- Workforce planning exercise completed for non acute settings:
 - ◇ Results disseminated to all non acute divisions for action.
 - ◇ Results used to collate estimates 2017 submission for CHO teams and HGs.

Antimicrobial Resistance Healthcare Associated Infection (ARHAI)

QI Major Project Areas for 201

Acute Hospital Focus

1. Implement STOP campaign to reduce IV line related infection in RCSI Hospital Group:

–Including “how to” guide development, development and implementation of care bundle, communications plan, baseline measurement and education programme.

Expected outcome:

- Establish national campaign.
- National guidelines/campaign materials.
- Measurement processes working with acute hospitals.
- Aim for an 80% reduction in device related blood stream infections.

2. Start Smart then Focus Acute Hospital Collaborative

–Finish cohort one of Start Smart the Focus Collaborative for acute hospitals.
–Start and deliver cohort 2 of Start Smart then Focus Collaborative.

Expected outcome:

- Improved compliance with antibiotic guidance.
- Reduced antimicrobial resistance.

CHO/Primary | Care Focus

1. CHO Hand Hygiene Focus:

- Develop branded tools as a result of HH train the trainer Pilot.
- Support Implementation nationally of train the trainer programme.

Expected outcome:

- All IPCN in non acute settings educated in new train the trainer programme.
- Measure of number of trainers trained.
- Measure of face to face training in CHOs.

2. Completion of Out of Hours Antibiotic Stewardship Project:

- Continue to support Out of Hours Antimicrobial Stewardship Policy.
- Review and Communicate outcomes of Out of hours project.
- Re-establish community antimicrobial stewardship committee.

Expected outcome:

- Reduced antibiotic prescription rate per consultation.
- Improved compliance with preferred antibiotics if one prescribed.

IPCN QI network:

- Plan and host x 3/4 network events for CIPCNs, QPS leads, PHNs, Practice nurses etc.
- Identify key areas/project ideas to focus on.

Expected outcome:

- Improved communication between CIPCN.
- number of project e.g. HH train the trainer.

National Pressure Ulcers Prevention Safety programme

Conclusion Pressure Ulcers to Zero Collaborative Phase 2

The National Pressure Ulcers to Zero (PUTZ) Campaign joint HSE/RCPI initiative concluded Phase 2 in June 2016. Multidisciplinary teams from the Ireland East Hospital Group, community organisations 5, 6, 8, and 9 and private residential nursing homes participated in the PUTZ collaborative learning sessions x 4.

The participating teams achieved a 49% reduction in pressure ulcers over a nine month period. There was evidence of sustain and spread of initiative in a few sites only. Capacity and capability within teams to transfer this learning to other projects system wide has not been measured.

Preparation & Planning PUTZ Phase 3

QID are responsible for the strategic planning/oversight and operational re-design and delivery of Phase 3. Planning commenced in October 2016. Focus of Phase 3 is on acute sector only and is being rolled out in 2 x locations for participating teams in SSWHG and DML HG with a total of 8 learning sessions. The primary aims is to reduce pressure ulcers by 50% across participating teams within a six month timeframe and to be sustained by 28th February 2018 and also to increase sustainability and spread of initiative across participating sites.

Key deliverables identified include:

- 100% participation of all teams at each learning session.
- Increase in knowledge and skills of participants in Pressure Ulcer Prevention.
- Increase in knowledge and skills of participants in Quality Improvement .
- 100% project site co-ordinators participation at coaching programme.

Programme Work streams

Aim: Pressure Ulcers to Zero by 2020 in Irish health care system.

With the exception of the PUTZ Phase 3, National Pressure Ulcers Prevention Safety programme commenced pre-planning in November 2016. There is a direct correlation between each work stream.

Work streams:

1. PUTZ Collaborative.
2. Cost savings projections of Pressure Ulcer Prevention in acute service.
3. Research: sustaining safety initiatives in practice (connected to other QID National Safety Programmes).
4. National Public Pressure Ulcers Prevention campaign event to coincide with World Pressure Ulcer Day.

Other Work sponsored by QID

Clinical Audit Training & Support

The Clinical Audit Training and support function delivers a one day clinical audit skills course to all healthcare staff wishing to undertake audit, and also offers support and advice to staff conducting clinical audits. Excel based audit tools are developed to enable staff to analyse the data from their audit.

The objective of the Clinical Audit training is to:

- Equip staff with the skills necessary to carry out clinical audits.
- Build capacity and capability within the service.

Four hundred and eighty four HSE staff received training in Clinical Audit Skills in 2016; this includes staff from Acute Hospitals (184), Community Health Organisations (299) and one member of staff from National Mental Health division. The feedback from these training courses was very positive and demand keeps increasing. A full breakdown of the training is available on the website at <http://www.hse.ie/eng/about/Who/QID/Other-Quality-Improvement-Programmes/auditsupport/>.

Audit tool templates have been developed to allow staff to develop their own audit tools, these tools analyse the audit data and present it graphically. Audit tools developed to date have been made available on the Quality Improvement webpage.

The following work has been conducted on national audit tools:

- An excel based tool is currently being used by the Sepsis Co-ordinators in each Hospital group .
- An audit tool has been developed for the dental service and is currently being piloted in CHO 1.
- A tool is being developed at the moment for Paediatric Early Warning Score (PEWS).
- Support to National Surveys.
- The clinical audit and support function also developed a tool to allow for the analysis of the Primary Care Service User Experience Survey at a local level and also collated the results nationally.
- A tool was also developed to allow for the analysis of the Sepsis Awareness Survey.

It is also recognised internationally that the setting and implementation of standards and monitoring compliance with them are important levers in driving improvements in quality and safety in healthcare.

RCQPS - Improvement Research Commissioning Process

RCQPS, collaboration between the Quality Improvement Division and the Health Research Board funds two projects per cycle up to the value of €280,000. The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals—a retrospective record review study, was the first study from RCQPS to be completed and published in BMJ.

Specialty QI Programmes in Histopathology, GI Endoscopy and Radiology

The Specialty QI Programmes are run by the Royal College of Physicians of Ireland (RCPI) and funded by the QID. The programmes are:

- The Histopathology National Quality Improvement Programme.
- The Radiology National Quality Improvement Programme.
- The Gastrointestinal Endoscopy National Quality Improvement Programme.
- In 2016, the Histopathology National QI report was published.

National Office of Clinical Audit (NOCA)

NOCA was established in 2012 to create sustainable clinical audit programmes at national level. NOCA is funded by the Quality Improvement Division and supported by the Royal College of Surgeons in Ireland (RCSI).

The current national audits governed by NOCA are as follows:

- Major Trauma Audit (MTA), clinically led by Dr Conor Deasy.
- Irish National Orthopaedic Register (INOR), clinically led by Mr David Moore, Mr Paddy Kenny, Mr James Cashman.
- National Intensive Care Audit (ICU Audit), clinically led by Dr Rory Dwyer.
- Irish Hip Fracture Database (IHFD), clinically led by Dr Conor Hurson, Dr Emer Ahern.
- National Audit of Hospital Mortality, clinically led by Dr Brian Creedon.

- National Perinatal Epidemiology Centre (NPEC) clinically led by Prof Richard Greene.







In 2016 annual reports were published for the National Audit of Hospital Mortality, the Irish Hip Fracture Database and Major Trauma Audit (2015). The Major Trauma Audit became the first National Audit endorsed by the National Clinical Effectiveness Committee.

Policies Procedures, Protocols and Guidelines (PPPG) Project

The HSE National Framework for developing PPPGs was developed and published in December 2016 and can be accessed through the following PPPG website link:

http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/PPPG_Document_Development_and_Inventory/

This framework sets out the standards that must be applied when developing PPPGs. In 2015, the National Clinical Effectiveness Committee (NCEC) in the Department of Health (DoH) developed '*Standards for Clinical Practice Guidance*' and in 2016 following an extensive literature review and survey the HSE National Framework for developing PPPGs has been developed, aligning the NCEC standards with the stages in the PPPG development cycle. This Framework sets out the following sections:

-  **Section 1: Definitions**
-  **Section 2: Stages in the PPPG Development Cycle**
-  **Section 3: Revised HSE National Template for Developing PPPGs (2016)**
-  **Section 4: PPPG Checklist for developing Clinical and Non-Clinical PPPGs**
-  **Section 5: Proposed HSE National Central Repository for HSE national approved PPPGs**
-  **Section 6: Implementation of the Framework**

A PPPG Education and Training Programme is being developed and will include a range of resource tools to support staff in developing PPPGs and will be available in 2017.

In parallel a National Central Repository Office (NCRO) will be established to hold all national approved PPPGs in a central location, facilitating access to staff and services users.

SCD/QID Quality Improvement Programme

Since Q1 2015, The Social Care Division (SCD) and the Quality Improvement Division (QID) have jointly resourced a cross-divisional Quality Improvement Programme to advise and support HSE residential services for adults with ID on enhancing structures and processes to improve the delivery of quality and person-centred services. The SCD/QID QI Programme has been the first established Programme of work to explore implementation of the tenets of the 'Framework for Quality' in health services.

Programme Teams comprised of both SCD and QID staff support residential services staff through coaching, mentoring and guidance to:

- Strengthen leadership and governance structures;
- improve relevant person-centred documentation;
- progress HIQA Action Plans and establish where further supports are required;
- identify areas of good practice and innovation for sharing across the service and
- implement quality improvement programmes to enhance the person-centredness of services.

Members of the Programme team have a range of relevant knowledge and competencies, and several have frontline experience as nurses, managers, care workers and practice development coordinators in disability services.

Programme teams advise residential services on areas for improvement identified in HIQA action plans, and offer services support to address some of the challenges they are facing.

Teams tailor their approach to each service to meet demonstrated needs, since services are at various levels of compliance and therefore have different requirements and priorities to achieve excellence as outlined by the HIQA National Standards. Independent support and advice from Programme teams offer fresh perspectives on the structure and operation of services; the exchange of knowledge, skills, and ideas for the benefit of service users; and help contribute to better informed management decision-making.

In 2016, SCD/QID Teams continued support of HSE residential services for adults with ID in CHO Areas 1, 4, 5, 6, and 8 as well as one voluntary service in CHO 3. Services have responded positively to the support offered by the SCD/QID Programme

Supports to National Disability Services Provided by SCD/QID Programme

Workshops: The SCD/QID Team is supporting the roll-out of area workshops for Persons in Charge (PICs)/Person(s) Participating in Management (PPIMs) of HSE residential services for adults with ID. The purpose is to provide ongoing support to PIC's to be effective in their role, and includes presentations from HSE services and HIQA as well as opportunities to network and share learning/innovations to address service challenges. In 2016, workshops took place with support of the SCD/QID Team in Donegal (June 2016), the Midlands (Sept 2016), Sligo/Leitrim (Oct 2016) and Cork/Kerry (Nov 2016). Post-workshop evaluations confirmed these were successful events, and welcomed by nurse managers. Further workshops are planned for 2017.

Project Toolbox: The SCD/QID Team developed a bespoke Toolbox for HSE adult residential ID services, which was launched in hard-copy in December 2015 and further developed as an online resource in Q4 2016. The Toolbox includes tools, guides, policies, templates, and signposts to resources from HIQA, the HSE, and other national bodies, and is aligned to the 18 outcomes upon which services are inspected by HIQA against regulations and standards. In December 2016, the team conducted an online survey of disability services on the efficiency and effectiveness of the Toolbox. Responses were positive, with the majority indicating a high level of satisfaction with the Toolbox e.g. 96% of respondents felt the Toolbox assisted them or their staff in working towards compliance with HIQA Standards and Regulations.

QI Training for Residential Services for Adults with ID - Integrated Training Plan and QI Diploma: The SCD/QID Team is liaising with stakeholders in HR, O&D, the ONMSD, the NMPDU, and other internal training and staff bodies in order to collaborate on an integrated training plan for staff of residential services for adults with ID. The SCD/QID Team is also working with the RCPI to develop a bespoke Quality Improvement course for staff in disability services.

Developing and Testing Governance for Quality and Safety: The SCD/QID Team have adapted a number of national tools to support services with improving their governance for quality and safety. In particular, the team developed a guidance document for conducting Management Walk-rounds of Designated Centres, which has been tested and well received in a number of services around the country. In November 2016, it was proposed to SCD-Disability Services for endorsement and circulation.

Global Health:

Memorandum of Understanding with Irish Aid: Collaboration with Mozambique: QI training programme began with two workshops for teams from the Ministry of Health and 15 hospitals.

ESTHER Programme: First ESTHER Partnerships Forum held in November

EQUALS Initiative: Memorandum of Understanding signed with Royal College of Physicians of Ireland; Collaboration started with Irish Medical and Surgical Trade Association; Collection of medical equipment for donation to Zambia

Further Information

More information is available on the Quality Improvement Division section of the HSE website:

<https://www.hse.ie/eng/about/Who/QID/>

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