TOWARDS EXCELLENCE IN PALLIATIVE CARE

Resource Document to Assist Completion of Specialist Palliative Care Quality Assessment and Improvement (QA+I) Workbooks

National Clinical Programme for Palliative Care, Clinical Strategy and Programmes Division
The QA+I Workbooks for specialist palliative care services support the implementation of the National Standards for Safer Better Healthcare. This resource document, developed by the National Clinical Programme for Palliative Care, has been designed to provide practical information to specialist palliative care (SPC) service when completing the workbooks. The workbooks can be accessed in the resources section on the programme website.

The document provides background information on a variety of topics relevant to the QA+I process, and signposts the reader to websites and documents that may assist with the process of evidence development and implementation. It is designed to be used as a practical repository, indexed in alphabetical order with space to add and update information so that the resource can grow and remain current. All links are active at the time of launch but are not intended as a definitive list but an addition to other national and international evidence under consideration by services. It is recommended that this document is also used in conjunction with the other resource documents developed by the Programme.

We welcome suggestions to improve and augment the Resource File and encourage you to contact the Programme Manager for the National Clinical Programme for Palliative Care clinicalprogrammeadmin@rcpi.ie and csp@hse.ie with your submission.
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Annual Controls Assurance Statement

As part of the HSE annual review of the effectiveness of the system of internal controls, all staff at Grade V111 (or equivalent) level and above are required to complete a Controls Assurance Statement, attesting to the existence and operation of controls which are in place in their area of responsibility. These forms are made available through the HSE annually and staff are notified usually towards the end of the year.

Alerts

The Health Products Regulatory Authority (HPRA) (formally known as the IMB) role is to protect and enhance public and animal health by regulating medicines, medical devices and other health products and issue alerts and safety notices. Further information about the HPRA can be found on [www.hpra.ie](http://www.hpra.ie). Irish Medication Safety Network also issues alerts and safety notices.

Alert: High Alert Medications

High alert medications are drugs that bear a heightened risk of causing significant harm to a service user when they are used in error. [www.ismp.org/tools/highalertmedications](http://www.ismp.org/tools/highalertmedications)
[www.imsn.ie](http://www.imsn.ie)
[www.ihi.org](http://www.ihi.org)

Adverse Event

An adverse event is an incident which results in harm to a service user (HIQA, 2012). See also [National Adverse Events Management System](http://www.aiihpc.org).

All Ireland Institute of Hospice and Palliative Care

The All Ireland Institute of Hospice and Palliative Care through its collaborative approach promotes strategic, evidence based contributions to the policy and practice environment across the island of Ireland [www.aiihpc.org](http://www.aiihpc.org)
Care Pathway
It is a multidisciplinary care plan that outlines the main clinical interventions undertaken by difference healthcare professionals in the care of service users with a specific condition or set of symptoms (Health Information and Quality Authority, (2012) National Standards for Safer Better Healthcare) [www.hiqa.ie](http://www.hiqa.ie)

Children


Clinical Audit
Clinical audit is the systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users. Health Service Executive (2014) *A Practical Guide to Clinical Audit*

Communication
*Speak to Me and Understand Me*
*Speak to Me and Understand Me* are two mobile apps developed by the Communicate Your Health Partnership. The partnership comprises of the HSE National Social Inclusion Office and the Interpreters in Palliative Care ‘On Speaking Terms – Matters of Life and Death’ development project. *Speak to Me and Understand Me* mobile apps [links](http://www.hse.ie/)

Competence
Competence development takes into account the incremental nature of knowledge attainment for skills based on experience and education. It also provides a basis for the development of clinical knowledge and career progression in health and social care.

Complaints

Health Service Executive (2010-2012) HSE *Health Inequalities Framework*.

Compstat
CompStat is the foundation of the operational performance measurement and
reporting process within the HSE. It is available to both statutory and voluntary agency information managers and clinical/management teams, as well as corporate users. www.healthatlasireland.ie

**Continuing Professional Development**

Personal development plans and personal learning plans are part of the concept of continuing professional development.

**Consent**

Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention.

Informed consent is the voluntary authorisation by a service user with full comprehension of the risks and benefits involved for any medical treatment or intervention provision of personal care, participation in research projects and provision of the service users personalised information to a third party.


**Continuity Of Care**

Continuity of care is a process involving the service user and service providers where they are engaged in the ongoing management of healthcare towards an agreed goal.

**Coordination Of Care**

Coordination of care within and between services takes account of service users needs and preferences (Health Information and Quality Authority (2012) National Standards for Safer Better Healthcare) www.hiqa.ie

**Culture**

Do Not Attempt Resuscitation (Dnar)

A do not attempt resuscitation (DNAR) order is a written order stating that resuscitation should not be attempted if an individual suffers a cardiac or respiratory arrest.


[www.hse.ie](http://www.hse.ie)
Early Warning Score
The early warning score categorises the severity of patients' illness through the:

- EARLY detection of patient deterioration
- Use of a structured COMMUNICATION tool (ISBAR)
- Promote an early medical review, prompted by specific TRIGGER points
- Use a definitive ESCALATION plan

See the Acute Medicine Programme for more information http://www.hse.ie/go/nationalearlywarningscore/


Environmental Walkabout Observation
The purpose of conducting an environmental observation is to allow the healthcare team to explore how person-centred the environment is for service users and how effective it is for to work in (HSE, 2010). The observation is conducted with the perspective of the service user in mind as well as staff. It is used to inform alterations /changes to the environment to benefit service users and staff.

Governance
The function of determining the services’ direction, setting objectives and developing policy to guide the service in achieving its stated purpose (HIQA 2008). [www.hiqa.ie](http://www.hiqa.ie)


Healthcare Records Management

Healthcare records management is the systematic and consistent control of all healthcare records throughout their lifecycle.


Health Promoting Palliative Care

Health promoting palliative care is a new concept in palliative care that has emerged over the past decade. It is based on the public health concept of a population approach linking to the World Health Promotion guidelines ‘the Ottawa Charter’.

The goals of public health palliative care have been described as:
- Building public policies that support dying, death, loss and grief
- Creating supportive environments (in particular social supports)
- Strengthening community action
- Developing personal skills in these areas
- Re-orientating the health system (Kellehear, 1999)


[http://www.compassionatecommunities.ie](http://www.compassionatecommunities.ie)

Human Resources

See HSE HR staff resources

Health Service Executive (2009) Dignity at Work Policy for the Health Service. Anti
Bullying, Harassment and Sexual Harassment Policy and Procedure.


http://www.hse.ie/eng/staff/Resources/hrppg/Trust_in_Care.pdf

Health Service Executive (2011) HSE Good Faith Reporting Policy.


Health Service Executive (2012) Garda Vetting and Assessment of Existing Employees in the Health Service.


Health Service Executive (2014) HSE Policy on Annual Certification of Registration of Social Workers with the Social Workers Registration Board at CORU.

Health Service Executive (2012) HSE Policy of Certification of Nurses and Midwives with An Bord Altranais. www.nursingboard.ie

Medical Professional Competence Scheme 
www.medicalcouncil.ie/Information-for-Doctors/Professional-Competence
Incident
The HSE definition of an Incident is - an event or circumstance which could have, or did lead to unintended and/or unnecessary harm (HSE Safety Incident Management Policy).

The State Claims Agency (SCA) is upgrading the web based system the HSE and relevant funded services use in order to report incidents to the SCA. This upgraded system is called the National Incident Management System (NIMS) formerly known as StarsWeb. NIMS is a confidential highly secure web based system. It is an end to end risk management tool that will allow the HSE and HSE funded services (where appropriate) to manage incidents1 throughout the incident lifecycle and identify emerging trends whilst also fulfilling the legal requirement to report incidents to the SCA. NIMS was designed in accordance with international and best practice standards, and legislative requirements to include the Safety, Health and Welfare at Work Act 2005. The design process involved consultation with subject matter experts and numerous external stakeholders. http://www.nimslt.hse.ie

Health Service Executive (2014) HSE Safety Incident Management Policy.


Information Governance
HIQA (2011) has developed a guide that gives practical information for health and social care staff around the management of information. The information governance self-assessment tool is an interactive list of questions to which service providers are asked to simply answer “yes” or “no to determine their compliance with information governance requirements and practices. It is a resource to be used by the management team of organisations for learning and development. It is designed to highlight areas where urgent action is required and where improvements may be made.

HIQA have also developed a document titled Guidance on Information Governance for Health and Social Care Services in Ireland (HIQA 2012). This guidance is aimed at helping healthcare professionals to improve how the health service handles service user information, and it provides practical examples on how to help prevent breaches from happening.

Integrated Care
Integrated care is the “processes, methods and tools” of integration that facilitate integrated care. Integration involved connecting the healthcare system (acute, community and primary medical) with other service systems such as long-term care, education or housing services (Leutz, 1999).


ISO 9001: 2008 is an internationally recognised quality management system (QMS) standard. It has been created to help organisations ensure that they meet the needs of their customers and other stakeholders while also meeting statutory and regulatory requirements related to the product. Further information is available at: www.certificationeurope.com/iso-9001-quality-management-certification/

Irish Association of Palliative Care
The Irish Association for Palliative Care established in 1993 is an All Ireland body that aims to promote palliative care nationally and internationally. www.iapc.ie

Irish Cancer Society
Since 1963 the Irish Cancer Society has grown into the National Charity for Cancer Care, the leading provider of all information relating to cancer prevention, detection, treatment and support. www.cancer.ie

Irish Hospice Foundation
The Irish Hospice Foundation is a national charity dedicated to all matters relating to dying, death and bereavement in Ireland. www.hospicefoundation.ie
**Key Performance Indicators**

Key Performance Indicators (KPIs) are measures of performance that are used by organisations to measure how well they are performing against targets or expectations. KPIs measure performance by showing trends to demonstrate that improvements are being made over time (HIQA, 2013).

Health Information and Quality Authority (2013) *Guidance on Developing Key Performance Indicators and Minimum Datasets to Monitor Data Quality*.

[www.hiqa.ie](http://www.hiqa.ie)
Identified Lead Healthcare Professional

The decision regarding the identified lead healthcare professional is made based on the specialty/healthcare team that a service user is attending or the lead healthcare professional (usually the consultant in charge) that is responsible and accountable for the care of the person.
(Palliative Care) Medicine Information

The Palliative Meds Info Service is a service providing information for health professionals on all aspects of drug therapy used in palliative care. This service is based in the pharmacy department at Our Lady’s Hospice in Harold’s Cross and responds to enquiries received by telephone or email. Further information can be found on: Palliative Medicine Information service and email palliativemedsinfo@olh.ie

Medication Safety

The Medication Safety Programme is charged with making practical improvements to the way medicines are managed, to deliver better, more efficient care to service users and to 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 (HSE, 2014). Health Service Executive (2014) Medication Safety.


High Alert Medications

www.ismp.org/tools/highalertmedications
www.ihi.org

Minimum Data Set

Minimum Data Set is a set of clearly defined data that is considered to provide important information on a service. The identification of specific data for collection facilitates:

- The measurement of activities and utilisation of a service.
- The management of resources with a view to improving patient care.
- Audit and research both nationally and by local services.
- Requests by individual services for additional resources.

(Sweeney, 2004).


Most Responsible Physician

The physician who has final responsibility and is accountable for the medical care of a patient.

National Adverse Event Management System (Formally Starsweb)

The National Adverse Event Management System (NAEMS) is a national web-based database for the reporting of adverse clinical incidence and ‘near misses’ (HIQA). The management organisation of the NAEMS is the Clinical Indemnity Scheme (CIS), State Claims Agency on behalf of the Department of Health. Recording adverse events and examining why and how they happened is an essential part of promoting a patient safety culture. It supports investigation and information for patients and their families, gives services an opportunity to analyse trends and continuously improve, and informs future planning of health services.

[www.hiqa.ie](http://www.hiqa.ie)  
[http://www.stateclaims.ie](http://www.stateclaims.ie)

National Advocacy Unit

The primary role of the national advocacy unit among others is:

- To insure the involvement of service users is central to how healthcare 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.

Follow this link for more information on the National advocacy unit

National Healthcare Charter

The National Healthcare Charter is a statement of commitment by the HSE on healthcare expectations and responsibilities. It outlines what service users can and should expect every time that they use health services, and what service providers can do to help deliver safer and more effective health services in Ireland.

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

Never Events

The term ‘never event’ was first introduced in 2001 by Ken Kizer, MD, Former CEO of the US National Quality Forum. It particularly refers to concerning medical errors (such as wrong-site surgery) that should never occur. Over time, this list has been extended to include significant adverse events that are clearly identifiable, serious (resulting in death or significant disability) and usually preventable (DoH, 2014).
Department of Health (2014) HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).


Open Disclosure
Services support an open, timely and consistent approach to communicating with service users and their families when things go wrong in healthcare. This is called open disclosure. A national policy and national guidelines on open disclosure with supporting documents which include a patient information leaflet, a staff support booklet and a staff briefing guide are available on from the HSE and State Claims Agency see [www.hse.ie/opendisclosure](http://www.hse.ie/opendisclosure).

Angela Tysall, is the National Lead for the HSE in Open Disclosure, and can be contacted at HSE Quality Improvement Division Donegal PCCC Headquarters, St Joseph’s Hospital, Stranorlar, Co. Donegal, Tel: 074 9191774, Email: angela.tysall@hse.ie

*Open Disclosure Pamphlet May 2015*

*Open Disclosure Staff Briefing Presentation May 2015*
Palliative Care Service Delivery Model

A service delivery model (SDM) sets out how a service will integrate and deliver its service. Each HSE service area is required to set out the service delivery model that supports the delivery of their care using a nationally agreed SDM if available, or an evidence-based model agreed through service/provider governance structures. Typically, a Specialist Palliative Care SDM would provide a framework for palliative care service providers (primary and specialist) to work together for the benefit of service users and their families. It would also include:

- How it provides for a comprehensive assessment of the service user’s palliative care needs and the needs of the family
- Determine a plan of care
- Improved co-ordination and collaboration between primary and specialist providers
- Reduced duplication
- Role clarity


Palliative Care Australia (2005) Standards for Providing Palliative Care for All Australians. www.pallcare.org.au

Canadian Hospice Palliative Care Association (2002) A Model to Guide Hospice Palliative Care: based on national principles and norms of practice. Ontario: Canadian Hospice Palliative Care Association


Palliative Medicine Information Service

The Palliative Medicine Information service is a service providing information for health professionals on all aspects of drug therapy used in palliative care. This service is based in the pharmacy department at Our Lady’s Hospice in Harold’s Cross and responds to enquiries received by telephone or email. Further information can be found on: Palliative Medicine Information service and email palliativemedinfo@olh.ie

Performance Review

A yearly performance review is an individual or team-based performance approach as part of an overall performance management review.
Person-Centred Care

“Person-centred care and support places service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users’ dignity, privacy and autonomy” (Health Information and Quality Authority, (2012, pp19).

The principles of person-centred care are based on treating people as individuals; respecting their rights as persons; building mutual trust and understanding, and developing therapeutic relationships (McCormack and McCance, 2010).


www.effectivehealthcare.ahrq.gov
http://hdl.handle.net/10147/115689
http://www.patient-centeredcare.org
http://www.health.org.uk/areas-of-work/topics/person-centred-care/
http://www.wanderingnetwork.co.uk/

Policy

A policy is a written operational statement of intent which helps staff make appropriate decisions and take actions, consistent with the aims of the service provider, and in the best interest of service users.

Prevention and Control of Healthcare Associated Infections

Healthcare associated infections (HCAIs) are infections, such as MRSA (Methicillin-resistant Staphylococcus aureus), that patients may acquire during the course of receiving treatment for other conditions within a healthcare setting. The ongoing reduction of HCAI rates is one of the most important challenges facing health and social care services (HIQA, 2009). Reducing these infections is vital to improve the quality and safety of care for people who use the health and social care services.

Tools and guidance that may assist you in your facility can be found at the links below:

- HIQA PCHCAI standards (2009)
- Health Service Executive (2013) Decontamination of Reusable Invasive Medical Devices Programme.
- Community Infection Control Guidelines (2011)
- WHO Hand Hygiene Guidelines: Outpatient and home-based care and long term care facilities (2012)

The following guidelines are available on the HPSC website at

- MRSA Guidelines (2013)
- Multi-drug resistant organisms, excluding MRSA guidelines (2013)
- Prevention of Catheter-Associated UTI (2011)
- Diagnosis & Management of UTI in residents of LTCF (2011)
- C. difficile infection (2013)

Antimicrobial prescribing for primary care (2013)
Immunisation Guidelines for Ireland (2013)
Public Health Guidance on Prevention & Management of Influenza Outbreaks in Residential Care Facilities (2013-2014)
Links to HALT Reports 2010, 2011 & 2013

**Productive Ward Initiative**

The Productive Ward: Releasing Time to Care™ is a quality improvement initiative with the aim of empowering front line staff to drive forward improvements in health services through redesigning and streamlining the way staff and services deliver care with an emphasis on patient safety. For more detail see [http://www.hse.ie/productiveward](http://www.hse.ie/productiveward)

**Protective Disclosure Policy**

Section 103 of the Health Act 2007, which came into operation on 1st March 2009, provides for the making of protected disclosures by health service employees. If an employee reports a workplace concern in good faith and on reasonable grounds in accordance with the procedures outlined in the legislation it will be treated as a “protected disclosure” (HSE, 2009). Follow the [link](#) for more information on protective disclosure.
Quality Improvement Interventions in Palliative Care

Quality improvement interventions in palliative care are targeted improvements for service users with life-limiting conditions. These improvements are conducted within or linked to the health care system and have at least some elements of system change, or intended change in how the system will interact with the service user and family. Examples of targets include service user and family satisfaction of palliative care; service user and family perceptions of palliative care; symptoms management and quality of care measures; grief and bereavement support; service access and health care utilisation.


Health Service Executive (South) (2012) *Towards Excellence in Palliative Care – Self Assessment Tool*.


Health Service Executive 2014) *National Clinical Programme for Palliative Care: Towards Excellence in Palliative Care Quality Assessment and Improvement Workbooks*.

**Quality Profile**

A quality profile provides an overview of the quality of healthcare a service is providing. Qualitative and quantitative information is derived from a variety of sources e.g. regulatory bodies, professional bodies, routine data collection, and audit and feedback from service users and staff. HIQA (2012).

Health Information and Quality Authority (2012) *National Standards for Safer Better Healthcare*. Published by HIQA.

**Quality And Safety Walk Rounds**

These service user safety walk rounds are a way of insuring that senior managers can build relationships and trust so they are informed and can exchange views, regarding the safety concerns of units/teams. They provide an opportunity for frontline staff to identify and discuss their safety concerns. They are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised. Walk rounds can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation.

Health Service Executive (2013) *Quality and Safety Walk Rounds Tool Kit, HSE Publication*. See
Quality and Safety Prompts For Multidisciplinary Teams

The quality and safety prompts are guiding principles for quality and safety. They can be used as a guide for action on quality and safety using the Plan, Do, Study, Act (PDSA) cycle. The prompts guide local team discussion on quality and safety with a focus on creating the environment and culture where excellence is embraced and can flourish with strong multidisciplinary team collaboration (HSE, 2013).

Rapid Discharge Planning
The aim of the rapid discharge planning guidance is to facilitate, smooth and seamless transition of care from hospital to community for persons who have expressed a wish to die at home. This document acts as a supplement to the Health Service Executive (HSE) National Integrated Care Guidance (HSE, 2014). Rapid Discharge Planning is driven by the wishes of the person and the carer and should be used in circumstances when a clinical situation has changed and there is an urgent request to enable the person to die at home. The National Clinical Programme for Palliative Care (2013) has produced a guidance document for rapid discharge planning which can be found on the programme website: www.hse.ie/palliativecareprogramme


Risk Assessment And Management
The HSE recognises the importance of risk management as an essential process for the delivery of quality and safe services. Risk Management is the planned and systematic approach to identifying, evaluating and responding to risks and providing assurances that responses are effective. Risk Management is a key element of good governance and underpins the ability to provide safe and effective care to our service users; it refers to strategies that reduce the possibility of a loss or harm. It consists of proactive and reactive components. Proactive components include activities to prevent adverse impacts, and reactive components include actions in response to adverse events. The HSE has in place a comprehensive integrated risk management policy with related procedures and tools available on the HSE website (www.hse.ie).

Health Service Executive (2011) Risk Management in the HSE. An Information Handbook


Health Service Executive (2009) Developing and Populating a Risk Register, Best Practice Guidance.

Safety Statement

A Safety Statement is a written programme in which an organisation specifies the manner in which the safety, health & welfare at work of its employees and others affected by its activities shall be secured and managed. The Safety Statement is based on the identification of hazards and the assessment of risk.


Health Service Executive (2008) **Best Practice Guidance for Developing a Site Specific Safety Statement.**

Health Service Executive (2012) **Garda Vetting and Assessment of Existing Employees in the Health Service. [www.hse.ie](http://www.hse.ie)**


Health Service Executive (2012) **Responding to Allegations of Elder Abuse. HSE Elder Abuse Policy.**


Service User

Throughout the National Standards and guidance the term service users is used. The term service user includes:

- people who use healthcare services
- their parents, guardians, carers and family
- their nominated advocates
- potential users of healthcare services.

The term ‘service user’ is used in general throughout this document but occasionally the term patient is used where it is more appropriate. Reference to service users does not include service providers who use services on behalf of their patients, for example, general practitioners using diagnostic laboratory services (HIQA, 2012).


Health Service Executive (2005) **Trust in Care.**
National Advocacy Unit
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- 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.

http://www.hse.ie/eng/services/yourhealthservice/contact/National/

Speak to Me and Understand Me
Speak to Me and Understand Me are two mobile apps developed by the Communicate Your Health Partnership. The partnership comprises of the HSE National Social Inclusion Office and the Interpreters in Palliative Care ‘On Speaking Terms – Matters of Life and Death’ development project. Speak to Me and Understand Me mobile apps

Your Service Your Say
Your Service Your Say is a guide to the HSE Feedback Policy. This guide outlines how the HSE will listen to and act on the feedback received from the people using the services. Health Service Executive (2009) Your Service Your Say – HSE Complaints Policy and Procedure Manual, Kildare: HSE www.hse.ie

Health Inequalities Framework
The Department of Health and Children has developed a number of policies with an important health inequality dimension

Health Service Executive (2010-2012) HSE Health Inequalities Framework.

Responding to Elder Abuse
Health Service Executive (2012) Responding to Allegations of Elder Abuse. HSE Elder Abuse Policy.

The National Centre for the Protection of Older People www.ncpop.ie
Work Related Stress

The HSE have developed a policy titled Policy for the Prevention and Management of Stress in the Workplace. The policy sets out a framework with the aim of identifying and reducing workplace stress. The state agency with responsibility for promoting health and safety at work in Ireland is the Health and Safety Authority (HSA). The HSA has published: *Work Related Stress – A Guide for Employers* and *Work Related Stress – Information Sheet for Employees*. Further information on employer and employee policies can be found on [www.hsa.ie](http://www.hsa.ie)
Y