HSE Directorate

Quality and Patient Safety Division

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality and Patient Safety Division

2013 Report

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Quality and Patient Safety (QPS) Division

The role of the QPS Division is to provide leadership, and be a driving force, in quality and patient safety by supporting the statutory and voluntary services of the HSE in providing high quality and safe services to patients their families and members of the public.

The division delivers on this role in collaboration with the HSE Divisions responsible for the delivery of services and regional quality and patient safety staff.

A work plan is developed on an annual basis to support the quality and patient safety objectives in the National Service Plan. This report reviews the work completed in 2014 in delivery of the 2013 plan.

Quality and Patient Safety plan for 2013

In the 2013 National Service Plan the key areas of work identified included:

- Building the capacity of key leaders across our healthcare system through the Diploma in Leadership in Quality Improvement and the associated site specific training so that quality improvement is embedded throughout the delivery system.
- Developing a culture of continuous quality improvement through effective governance structures, clinical effectiveness, outcome measurements, and evaluation remains at the centre of our approach to improving services.
- Extract the learning from managing incidents, complaints, and the rolling programme of healthcare audit. All of these processes give rise to important learning which we must ensure will lead to changes in healthcare practice in order to avoid repeating mistakes and better guarantee the safety and quality of care for patients.
- Inform and empower service users to actively look after their own health, and to influence the quality of healthcare in Ireland through applying the principles oh the patient charter - *You and Your Health Service.*
- Continue to work with the Department of Health in the setting up of the new Patient Safety Agency (to be established on an administrative basis) as outlined in *Future Health*.
- Progress actions to work towards meeting the *National Standards for Safer Better Health Care,* launched by the Health Information and Quality Authority (HIQA) in 2012 by working closely with frontline service providers to support them in working towards meeting the National Standards.

Overview of 2013:

2013 has been a year of significant change within the HSE with the establishment of the HSE Directorate, the set up of the five service divisions (Acute services, primary care, health and wellbeing, mental health and social care) and the establishment of the first hospital groups.

This level of change can have associated risks for users of the services as governance arrangements change and new structures take over. Throughout these changes the

QPS Division has continued to support services to maintain a focus on quality and patient safety.

Key areas of support included quality and safety governance development, clinical directors' programme. Leadership development through the Quality Improvement Diploma, management of serious adverse events, support for the implementation of the National Standards for safer Better Healthcare, Service users involvement and feedback, consent and clinical audit.

The establishment of the Organ donation and Transplant Office with the QPS Division is a major milestone in this area.

Advocacy

The primary objective of the advocacy unit is to ensure that the involvement of service users is central to how health care services are designed, delivered and evaluated and the unit supports service users and staff to deliver on this goal. The progress made in 2013 includes:

A staff guide – 'Using Patient Feedback' was published to support services to achieve a real measure of the patient experience as they go through the system.

A 'Patients for Patient Safety Ireland' (PFPSI) group was established, based on a World Health Organisation initiative aimed at improving patient safety in health care. Sixteen members of PFPSI received formal World Health Organisation designation. The purpose of setting up a network of PFPSI is to promote understanding and dialogue around patient safety and the role patients can play in developing new approaches to improving patient safety.

The launch of the HSE 'Open Disclosure Policy' and 'National Guidelines' represents a significant advancement in the change in culture required to have an open and transparent relationship between the patients/service users and health and social care providers, especially after care has been sub-optimal. The policy and guidelines reflect joint work with the State Claims Agency, the feedback from many groups and bodies nationally to the draft documents, and the learning from the pilot implementation in two major hospitals.

www.hse.ie/opendisclosure

Following on from previous work in the development and launch of a Patients Charter, the principles of the National Children's Charter were published in conjunction with the Ombudsman for children. These will form the basis of a full charter in 2014.

(www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/)

Quality Improvement

Diploma in Quality and Leadership

This programme, in collaboration with the professional colleges, is aimed at increasing the capability and capacity of managers and clinical leaders to proactively initiate and deliver quality improvement within their services. During 2013 the

programme has delivered the Diploma in Leadership and Quality in Healthcare: 50 participants started training in two cohorts in Q4 2013

The regional training with National Leadership and Innovation Centre for Nursing and Midwifery to reduce rate of falls in Limerick Regional Hospitals is continuing. It will end Q1 2014 and has brought falls down to zero where implemented.

A second cross border patient safety programme a joint undertaking with RCPI and HSC Safety Forum in NI, funded by CAWT will start in Q1 2014.

Pressure Ulcer Collaborative

There has been significant development of a Pressure Ulcer Collaborative to start in Q1 2014;

- A steering group was established in Q3 2013 consisting of relevant representatives to lead and support the development
- Dublin North East was confirmed as the first region for this Collaborative in Q4 2013
- Acute, Primary, Residential and Community care units have been invited to participate

The first learning session will start in Q1 2014 and the Collaborative will run until Q3 2014

Quality and Patient Safety Programmes

QPS Quality and Safety Governance Development

The vision for this development programme is that each individual, as part of a team:

- knows the purpose and function of leadership and accountability for good clinical and social care;
- knows their responsibility, level of authority and who they are accountable to;
- understands how the principles of clinical governance can be applied in their diverse practice;
- consistently demonstrates a commitment to the principles of clinical governance in decision making

Support materials for clinical governance development for use across the continuum of care has been developed, published and communicated to the services. These include:

- Quality and Safety Walk-rounds: toolkit (2013)
- Quality and Safety Committee (s): guidance and sample terms of reference (2013)
- The Safety Pause: Information Sheet (2013)

Other supports include the inclusion of four Patient Safety Toolbox Talks for the QPS Dublin North East initiative and a monthly column on Quality and Safety prepared for World of Irish Nursing Journal (Irish Nurses and Midwives Organisation).

Integration of clinical governance across HSE initiatives delivered in 2013 include QPSA Audit of Accountability; review of Management Controls Handbook, Controls Assurance Statement and Questionnaire; baseline assessment of staff perception of

clinical governance development; and advice to the national clinical programmes and services.

Support for the establishment of Clinical Governance structures in acute and primary care services was delivered during the year. In acute services a multidisciplinary project team led by the clinical director, with a project manager and agreed terms of reference, assessments and action plans was established in Connolly Hospital, Cork University Hospital, Midland Regional Hospital Portlaoise, Sligo Regional Hospital; and Wexford General Hospital. Progress reports were produced during the process and final reports were submitted to the Steering Group and joint evaluation meeting on the 18th September 2013.

In Q3 two primary care teams and associated primary care managers commenced a similar process in HSE West and South.

Clinical Directors

As new structures and hospital groups come into effect in the HSE support for clinical directors in their challenging roles is an important programme for the QPS Division. During 2013 the programme has delivered tangible benefits to services. These include:

Education and Training –

- workshops and master classes (Managing professional conflict, risk management)
- Directorate management training (CUH)

Guidance:

Guidance document on development of Clinical Directorates within Hospital Groups.

Assisting with **governance structures** – West and MidWest hospital groups

North West Cardiology Review - review of Cardiology services in NW. Innovative cross-border solution among recommendations: accepted in full by new West North-West Board in October and now proceeding to implementation.

Liaison role: Individualised site/area specific work (examples: consultant contract, CD authority, conflict with colleagues etc)

Consultant recruitment survey – informed position paper for HSE

Unscheduled Care - Guidance on Clinical ownership, Handover/Handback, of patients

NCHDS support:

Lead NCHD project rolling out 2014 – 8 pilot sites (in consultation with Postgraduate Training Forum, Trainees)

Clinical resource to HSE at LRC and on site validation visits during NCHD industrial dispute (www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/National_Consent_Advisory_Group/National_Consent_Policy.html)

Healthcare Acquired Infection (HCAI) and Antimicrobial Resistance (AMR) National Clinical Programme

The overarching principle of the RCPI and HSE clinical programme for the prevention of healthcare-associated infection (HCAI) & antimicrobial resistance (AMR) is that every patient/resident/client receives high quality safe health care irrespective of where healthcare is delivered, in a healthcare system where the acquisition of HCAI and AMR is minimised.

The aim is to ensure that HCAI and AMR are not inevitable consequences of healthcare and that every healthcare worker in all parts of the healthcare system recognises that infection prevention is a key element of clinical and non clinical governance. The programme aims to get back to basics, enabling staff to focus on three areas consistently and reliably every time they care for patients.
These are:

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

Hand hygiene

Education and training:

- Workshop for hand hygiene educators, trainers and auditors with WHO experts
- Educational materials for staff: Hand Hygiene video on 5 moments; new Hand Hygiene posters;
- Biannual education for lead hand hygiene auditors.(train the trainers)
- WHO hand Hygiene day 2013 marked with hand hygiene news letter including lead article from patient advocat, articles in health matters, emails to all HSE staff and poster campaign.
- New hand hygiene website: www.HSE.ie/go/handhygiene

Hand Hygiene guidelines:

- Updated in line with WHO guidelines
- National Specification for for alcohol based hand rub was developed.
- Hand Hygiene audit software tool for hospital audits developed in conjunction with HPSC which eases reporting of data nationally & allows immediate feedback of local results for incorporation into improvement programmes.

Antibiotic stewardship

Antibiotic Guidelines delivered:

- MRSA updated guidance – Endorsed by NCEC, Launched by Minister, Dec 2013
- Guidelines for prevention and control of multidrug resistant organisms
- Community Antibiotic Guidelines (smart phone/tablet format) www.antibioticprescribing.ie
- Care bundles for hospital prescribers - 'Start smart then focus'
- QI collaborative on Gentamicin prescribing

Education and training:

- Antibiotic Awareness day November 2013, RCPI - launch of public information campaign & CPD education for prescribers
- Public information campaign on antibiotics – antibiotics don't work on colds & flu's
- Public evening on antibiotics in RCPI
- Update of HSE antibiotic homepage www.hse.ie/go/antibiotics with new materials including
    - New videos on antibiotics & AMR
    - New materials for download for GP's surgeries & community pharmacies
    - Updated information leaflet on antibiotics
    - New links to A-Z (HCAI & antibiotics
- Engagement with schools – Science Week – Design a bug competition for primary schools
- Prescriber education within an RCPI e learning module / ICGP meetings / RCPI & ICGP e zines

Medical infections associated with medical devices

- QI tool for the prevention of surgical site infection published in conjunction with RCSI
- Unit acquired bloodstream infection surveillance protocol finalised in conjunction with critical care programme
- National Long term care facility HCAI and Antibiotic use (HALT) study completed in 191 LTC facilities
- Urinary Catheter care bundle revision and updated audit tool published

http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/HCAI_Programme

National Standards for Safer Better Healthcare

The Safer Better Healthcare -Acute Care Collaboration was established to agree and facilitate a consistent national approach to implementing the National Standards within the acute hospital setting. Part of this work has been to develop a Quality Assessment and Improvement (QA+I) Tool to support services to assess against the Standards. This tool has been developed in collaboration with service providers across the system. It is available as a web enabled tool and is complemented by eight individual workbooks which reflect the themes of the National Standards.

Workshops have been delivered to support the use of the QA+I tool in acute services.

QPS has also worked in collaboration with the Ambulance Services to customise the tool to their requirements.

http://hse.ie/eng/about/Who/qualityandpatientsafety/Standards/nationalstandards/

Medication Prescriptions & Administration Records (MPAR)

A draft MPAR has been produced following a national consultation process and two pilot usage trials. The options for implementation of all or part of the MPA will be evaluated with the chair of the Medication Safety Advisory Group in early 2014.

Quality Assurance

Quality and Patient Safety Audit

The Quality and Patient Safety Audit service completed a full programme of audits in 2013. During the year, the QPSA auditors commenced seventeen new audits and completed sixteen audits; six audits are currently in progress and due to be completed in Q1 2014.

The QPSA audits undertaken in 2013 dealt with diverse services and areas including primary care, inpatient and community mental health services, intellectual disability services, acute and pre-ambulatory care, and HSE-funded services. The majority of audits examined services' compliance with standards and recommendations; policies, procedures, processes and guidelines; and report recommendations. Other audits analysed governance structures, patient complaints and referral patterns. Three auditors have been participating in the year-long Irish National Audit of Dementia Care in Acute Hospitals, due to be completed in Q1 2014.

Executive summaries of completed audits are available on the website, and a 2013 end of year report (encompassing three year review) will be produced in early 2014.

http://hse.ie/eng/about/Who/qualityandpatientsafety/auditservices/

Clinical Audit

National Office for Clinical Audit:

The establishment of the National Office for Clinical Audit (NOCA – www.noca.ie)

Through collaborative agreement between the Quality and Patient Safety Directorate of the Health Service Executive (HSE) and the Royal College of Surgeons in Ireland (RSCI), RSCI is providing administrative and operational support to the National Office of Clinical Audit. NOCA functions through an Executive Team which provides managerial and operational support to deliver the objectives of the NOCA Governance Board. The NOCA Governance Board is an independent voluntary Board, which oversees the establishment of sustainable clinical audit programmes in agreed specialties. The central aim of all NOCA audit streams is to improve clinical services for patients in Ireland.

The audits identified for delivery in 2013/14 are:

- *Irish National Orthopaedic* Register *(INOR)*
- *National Intensive Care Audit (ICU Audit)*
- *National Emergency Medicine Audit (NEMA)*
- *Irish Audit of Surgical Mortality (IASM)*

A Practical Guide to Clinical Audit

The Quality and Patient Safety Directorate has developed 'A Practical Guide to Clinical Audit' to eliminate such confusion and to equip healthcare professionals with the necessary knowledge to plan, design and conduct a clinical audit.

The document will:

- Act as a learning resource for those who are new to clinical audit.
- Provide a reference guide for healthcare professionals already involved in clinical audit.
- Equip healthcare professionals with the necessary knowledge to plan, design and conduct a clinical audit.
- Enable healthcare professionals to be proactive and to make changes which contribute to overall quality improvement within their services.

Quality Indicators /Quality Profile

In 2013 the National Quality and Patient Safety Indicator Steering Committee and Technical Group have selected of fifteen QPS indicators for development and inclusion in NSP 2014. The indicators will be included in the new Patient Safety Indicator level within Compstat. Currently eight 8 pilot sites are testing some of the new indicators in this new level in Compstat. This is an important step in having QPS indicators profiled, reviewed and acted on a par with the financial, activity and workforce data.

An outline Quality Profile has been drafted and circulated to the regions. This is to guide the services and sites on the type of information that might be collected for their services and reviewed periodically by the Clinical Governance Committee and the Senior Management Team.

Guidance and Support for Quality and Patient Safety Processes

Consent

Consent must be obtained before starting treatment or investigation, or providing personal or social care for a service user or involving a service user in teaching and research. The legal framework in Ireland regarding informed consent for health interventions, social care interventions, and childcare is fragmented and not very clear. QPS, through an advisory group, in consultation with a very wide range of stakeholders has developed and published a national policy on consent. The guidance document has companion guides for service users, healthcare professionals and minors. The guidance in the policy will provide all users and care givers strong support in following best practice for informed consent throughout the services.

Integrated Discharge Planning

Revised guidance has been completed following a series of consultation exercises with all relevant stakeholders. The guidance will be published at the end of January 2014.

Patient Safety Culture Survey

This survey is the first in the HSE to establish the current views of staff on patient safety. Following on the Post pilot in 2012/13 (5 hospitals) the full survey of all acute hospitals commenced in 2013. Phase 1 (18 hospitals) has been completed and survey reports are being compiled at present. Phases 2, 3 and 4 (20 hospitals) have completed the survey and data is being collated. Phase 5 (4 hospitals) is due to commence mid Jan 2014.

Individual reports will be developed and delivered to each hospital and a nation composite report will be developed when all hospitals are completed.

The reports for the initial five pilot sites have been delivered and results reviewed with the hospitals.

National Policy and Procedure for Safe Surgery

The working group completed its work in 2013 and the National Policy and Procedure for Safe Surgery was launched by Minister for Health in July. This is an important policy that will help to reduce the incidence of wrong site surgery in our services.

Decontamination

Hazard Alert System is live in Dublin North East region and will be live in other regions in early 2014

Implementation of recommendations from Major investigations

The QPS Division has continued to work with the services on the implementation of recommendations from major reports. In 2013 support groups were in place for the HIQA Tallaght and HIQA Galway reports. These implementation support groups provide oversight and guidance for the HSE management team on how the recommendations should be implemented; establish sub groups to deal with particular clinical issues; and monitor the implementation across the system.

Healthcare Records Management

Ongoing support was provided to hospital services on the implementation of the standards and recommended practices for healthcare records. Work is continuing on consultation and revision of Standards and Recommended Practices for Healthcare Records Management (V4.0).
http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/healthrecordsmgt/

National Incident Management Team (NIMT)

The NIMT is a resource available to all Divisions in the HSE to provide support for incident management.

The NIMT oversaw or directly managed a number of serious incidents in 2013 including an incident of a tragic maternal death that occurred in October 2012. The report of this NIMT investigation was published in June 2013 and has been recognised as robust and of high quality.

There were 49 cases on the log at 1st Jan 2013, 57 we escalated to NIMT during 2013, 98 cases were de-escalated which left 8 cases with NIMT at the end of the year.

During 2013 the focus of this team shifted from direct management and oversight of incidents towards supporting and training management teams to manage and investigate their own cases more effectively. This enabled NIMT resources to focus on distilling learning from completed incident investigations to better inform local and national safety interventions. The core team worked with the Health Intelligence group to deliver an analysis of the key themes emerging from investigations of death and serious harm events that were completed during the 2010-2012 periods.

The core team has worked with HSE Stakeholders and the State Claims Agency on the development of a National Incident Management system.

During 2013 the NIMT continued to consult and engage with internal and external stakeholders to update National Incident Management Policy and an updated draft was delivered to the HSE Leadership Team in November. Following feedback, the updated version will be published in early 2014.

http://hse.ie/eng/about/Who/qualityandpatientsafety/incidentrisk/

Paediatrics

The QPS Division has contributed significantly to the development and improvement of the paediatric services in the HSE, including cross border initiatives. The key elements delivered in 2013 include:

- Draft Policy and Standards of Care for General Paediatric Surgery
- Paediatric Critical Care Network
- Continued engagement with the stakeholders in the implementation of the 2012 Clinical Review in areas of Clinical Audit, Referral Pathway and Training
- With the Paediatric Clinical Care Programme leads met with 34 paediatric specialities to review services, audit, KPI's etc to inform service developments in relation to national model of care that is underpinned by quality and safety for children
- Continued engagement in the consultation process with NI with regard to all island cardiac surgery service

National Organ Donation and Transplantation Office

The remit of this office is to ooversee the development, implementation and upkeep of a Quality and Safety Framework applying to the procurement, allocation and transplantation of organs; ensures a reporting system is in place for adverse events relating to the quality and safety of organs from donation to transplantation recovery; keep a record of and publish data on all procurement and transplantation activities; supervises organ exchange with member states; and ensure a register of living donors is kept. In 2013 the office has developed a service plan to reach the volume and quality targets required to meet international best practice.

Key priorities for 2014

The 2014 National Service Plan outlines the key Quality and Patient Safety objectives as

- Ensure that each Director and the managers and clinicians within their areas of service are responsible and accountable for ensuring the provision of safe, quality services
- Support quality improvement initiatives across the health services that aim to enhance patient safety
- Improve the experience of patients and service users within the health services
- Ensure that standards, policies and guidelines are understood and appropriately implemented by Health Service staff.
- Put in place a comprehensive set of quality and safety indicators to measure the quality and safety of our services

All Health Service staff, individually and collectively, have a responsibility for the quality of the services they deliver to the patients and service users in their care, and must integrate a commitment to quality and safety into their core work and practice.

The key focus areas for quality and patient safety in 2014 are:

- Commitment to supporting the development of an open and transparent culture with defined accountability for quality and safety
- Clear governance and accountability for quality and safety at all levels of the Health Service and Divisions
- Improving the patient experience within health services
- Supporting quality improvement throughout the health system to improve outcomes and reduce patient harm
- Ensuring that standards, policies and guidelines are understood and appropriately implemented
- The development and use of a comprehensive set of quality and safety indicators to measure the quality and safety of our services and take appropriate action to improve poor performance including medication safety, healthcare associated infections (HCAI) and the national early warning score (NEWS)
- Ensuring that there is robust risk assessment (from a patient safety perspective) of any reconfiguration of services required to meet financial and staffing constraints
- Continued development of the controls assurance process that requires all managers to provide assurance on their accountabilities for clinical and social services to the same level as is required for financial accountability

The QPS Division will continue to work with services, regional structures and external stakeholders to deliver on these priorities in 2014.

Contribution from staff:

The progress made in 2013 is a reflection on the contribution from staff all across the service delivery system to the Quality and Patient Safety agenda. This contribution included chairing/membership of committees, workgroups, advisory groups; reviewing documents and processes and providing good feedback; partaking in pilots and evaluations; implementing new policies and work practices; providing training and support to colleagues; and sharing learning and good practice.

Quality and Patient Safety is everyone's responsibility and the achievements in 2013 demonstrate that this responsibility is put into practice by many people across the HSE.

HSE Quality and Patient Safety Division: Draft V7: January 27th 2014