HSE Directorate

Quality and Patient Safety Division

2014 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.

From January 1st 2015 elements of the division moved to the new division; Quality Assurance and Verification Division. In 2015 the name of the Division changed to Quality Improvement Division (QID) and the primary focus will be on quality improvement.

Quality and Patient Safety Plan for 2014

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

Underpinning the delivery of all our services is the commitment to ensuring high quality and safety. This will remain an important focus in 2014. In particular the Health Service will:

- 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

Overview of 2014:

2014 has been another year of significant change within the HSE with the reform of regional structures and the establishment of hospital groups and community healthcare organisations as the core provider organisations.

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 continued to be quality and safety governance development, clinical directors' programme. Leadership development through the Diploma in Leadership and Quality in Healthcare 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 information and analysis unit within the division will be a key enabler for future development of quality improvement.

The publication of the quality and safety enablement programme in Q4 started with a major change process within the division. At year end 2014 the national Incident Management Team moved into the new Quality Assurance and Verification division.

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. In 2014 the key achievements of the Advocacy Unit were focused in the following areas.

Open Disclosure

- 2014 was focused on the implementation of the open disclosure national policy:
    - 47 acute hospitals now engaged in the implementation of open disclosure, many at advanced levels of engagement.
    - 2 CHO's engaging with work undertaken in 7 counties.
- Train the trainer programme was developed and piloted.
- The independent evaluation of the pilot sites commenced.
- 1 day workshop was developed and delivered in RCSI.
- Work commenced with RCPI QA programme.
- Several journal articles submitted as part of our plan to increase awareness.
- Work commenced on the development of additional open disclosure resources
- Condensed workshops delivered to graduate nursing students from St Angela's College in Sligo and Letterkenny Institute of Technology.

Accessibility

- National Guidelines on Accessible Health and Social Care Services were completed.
- The purpose of the guidelines is to:
    - assist health and social care providers to comply with legal obligations under the Equal Status Acts, the Disability Act 2005, the associated statutory Code

of Practice on Accessibility of Public Services and Information provided by Public Bodies and health and social care policy and procedures
    - assist health and social care providers to meet the principles of the National Healthcare Charter 'You and Your Health Service'
    - assist health and social care providers to meet the provisions of the National Standards for Safer Better Healthcare 2012 (HIQA)
    - provide a resource for Access Officers to support health service staff respond to the access requirements of people with disabilities in all HSE health and social care settings
    - provide a guidance document for use in education and training in relation to disability, accessibility and customer care
    - provide a reference manual for all staff.
- Nationwide Access Officer training commenced in a number of locations
    - 70 Access Officer trained in 2014
    - 140 Access Officers to receive training in 2015
- Draft model of care on transgender health developed. Consultation process commenced.

Advocacy

- During 2014 the HSE has along with Atlantic Philanthropies invested in a Volunteer Advocacy Programme for older people through the auspices of Third Age (Sage) that will make independent advocacy available in Acute Hospitals, Long Stay Residential Units, Primary Care Centres and in the community.
- 100 volunteers are currently being interviewed and Garda vetted and training is commencing shortly. These will supplement the 100 volunteers already trained.
- It is proposed to extend a similar service to people with disabilities living in residential units in the near future and discussions on this are about to get underway with groups representing people with disabilities.
- In 2014 the Advocacy Unit undertook listening exercises with older people under the auspices of the Age Friendly Counties in Galway, Kilkenny, Meath, Kildare and Dublin City North West
- Listening sessions will continue in 2015 and it is intended to expand the remit to include all age groups and settings.

Patients for Patient Safety Ireland

- Work continued in 2014 on facilitating and support the work of Patients for Patient Safety Ireland (PFPSI)
- A number of PFPSI members are involved in various activities, including conducting a patient survey in a local hospital, presenting at a patient safety conference, representation on NOCA national audit governance committee and National Clinical Effectiveness Committee (NCEC).
- Expressions of interest have been sought from PFPSI for the Hospital Group Boards and the Strategic Advisory Group.

Training in the theory and standards of patient safety and Open Disclosure was provided to the group.

Quality Improvement

Diploma in Leadership and Quality in Healthcare

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 2014 the programme has delivered the

Diploma in Leadership and Quality in Healthcare: 50 participants started training in two cohorts in Q4 2013

QI Expert Coaching Programme

As part of the National Quality Improvement (QI) Programme and building on the Diploma in Leadership and Quality in Healthcare, this new QI Expert Coach programme commenced in July 2014 with 20 participants. The aim of the programme is to establish QI experts in the Irish healthcare system with specific knowledge and skills in coaching the teaching QI locally in order to spread and sustain improvements within their organisation.

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 signicantly where implemented.

Cross Border Patient Safety Programme (CAWT)

A third cross border safety programme is a joint undertaking with the National Quality Improvement Programme, Quality & Patient Safety and HSC Safety Forum in NI, funded by CAWT commenced in QI 2014 and completed in February 2015. In total thirteen teams presented on their patient safety projects on the final day. A significant outcome from this programme was the collaboration of six teams from Services for Older Persons supported by allied multidiscipline leads in the community in DNE to successfully reduce falls across older person services across Cavan and Monaghan. Falls in older person services was reduced by 58% over a six month period by the six teams.

Pressure Ulcer Collaborative

The National Quality and Patient Safety Division, HSE in partnership with the National Quality Improvement Programme and the Regional Quality and Safety Team within the former North East Region undertook the first large scale quality improvement Collaborative in Ireland – Pressure Ulcers to Zero. The aim of the Collaborative was to reduce the incident of avoidable pressure ulcers across Dublin North East by 50% between February to September 2014. Twenty teams from across acute, residential and community services within DNE in this quality improvement initiative.

The Improvement Collaborative methodology was developed by the Institute for Healthcare Improvement (IHI) and provides a structure for teams to come together to focus their improvement efforts on one specific area. The teams are supported in implementing best practices through exposure to quality improvement knowledge, methods and tools and making rapid, sustainable changes from small scale tests of change.

and the Royal College of Physicians of Ireland, as part of the National Quality Improvement Programme undertook the first large scale quality improvement Collaborative in Ireland – Pressure Ulcers to Zero - in partnership with the Regional Quality and Safety Team within the former North East Region. The focus of the Collaborative was to reduce the incidence of avoidable pressure ulcers across Dublin North East by 50% between February to September 2014. An impressive 21 teams from across acute, primary and community services within DNE participated in this quality improvement initiative.

The Improvement Collaborative methodology was developed by the Institute for Healthcare Improvement (IHI) and provides a structure for teams to come together to focus their improvement efforts on one specific area. The teams are supported in implementing best practices through exposure to quality improvement knowledge, methods and tools and making rapid, sustainable changes from small scale tests of change.

On completion of the Collaborative the teams achieved a 73% reduction in avoidable pressure ulcers across the services in Dublin North East. Since the completion of the collaborative, teams have been supported with sustainability and spread and there continues to be a

collective focus to achieve spread and the ultimate aim of pressure ulcer to zero within our health service.

Results:

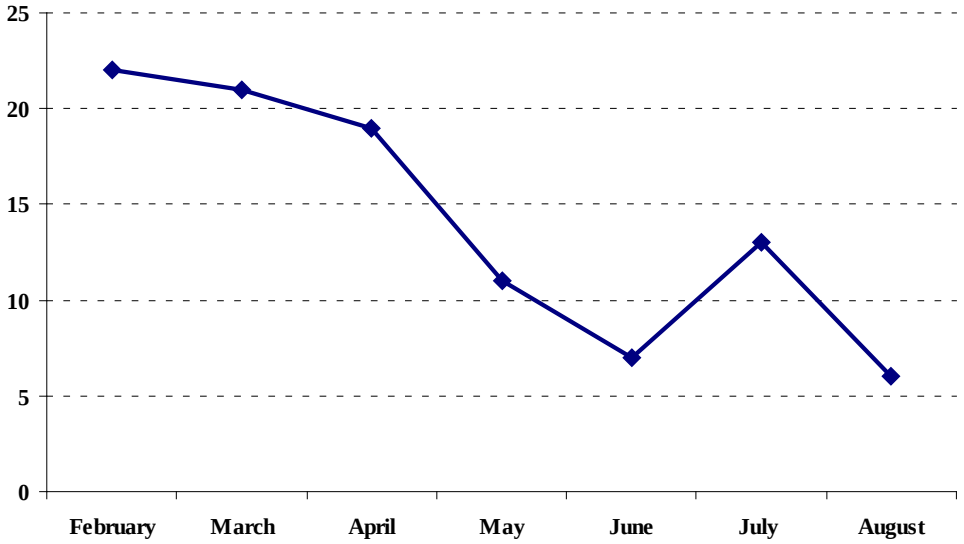

Figure 1: The trend in the reduction of the numbers of pressure ulcers amongst the participating teams from February to August 2014.

Next Steps:

1. Support teams within this Collaborative to sustain and spread their achievements in reducing pressure ulcers.
2. Plan the best approach to spreading this Collaborative across the Irish healthcare system.

Quality and Patient Safety Programmes

Governance for Quality and Safety Programme

The *Report of Quality and Safety Clinical Governance Development Initiative: Sharing Our Learning* was published in May 2014. The report recommendations for health service providers, commissions and policy makers, were shared with each national director and are incorporated in the HSE National Service Plan for 2015.

The learning from the three year initiative was further disseminated through the HSE website, newsletters, education programmes, in a poster presented at *4th National Patient Safety Conference*, (November 2014) and upcoming publication in the *Journal of Health Management and Organization*.

Primary Care

A tailored quality and safety clinical governance development initiative for primary care was completed in November 2014. Teams in North Cork and North Sligo were selected, complementing the involvement of Sligo Regional and Cork University Hospitals in the overall initiative by the National Primary Care Steering Group and Regional Directors of Operations.

The projects commenced in September 2013 with the setting up of a project team to manage each project. Six facilitated half day workshops were held across the two projects, three for primary care team members and three for Primary Care Managers. Workshop participants completed the *Quality & Safety Prompts for Multidisciplinary Teams* and the *Assurance Check for Health Service Providers as appropriate* (modified for primary care). Completion of the tools facilitated the development of actions / quality improvement plans. Key actions focused on strengthening primary care quality and safety structures and processes in keeping with the *Governance for Quality and Safety Framework* (2014) A Joint learning meeting was held on the 26th November 2014 with the objective to: (i) explore what worked for each Action Project, (ii) gain specific understanding of the learning from identified actions / quality improvement plans, (iii) explore how the overall learning could be harnessed to support the assessment and implementation process for the National Standards and (iv) identify how the learning could be disseminated and used. A final report of the primary care initiative will be published in early 2015.

Measuring Clinical Governance Development

The Clinical governance development index (CGDI) was incorporated within in national hospital patient safety culture survey. The index provides a measure of staff perception of clinical governance development within their services. Individual results were shared with each service and HSE Directorate Risk Committee. The average score across 41 hospitals was 47%.

Quality and Safety Committee(s)

A mapping of Quality and Safety Committees within services was completed for 2013 and shared with National Directors and the HSE risk committee. The publication of the *Quality and Safety Committee(s): guidance and sample terms of reference* in May 2013 has assisted services in developing their Committee structures (available at www.hse.ie/go/clinicalgovernance.ie). Between 2012 and 2013 there were an additional 42 health service providers reporting into a quality and safety committee, this is a 15% increase on 2012. Responses indicate that 246 of the 341 committees in the responses for 2013 have formal terms of reference for their committee. Also 51 additional committees reviewed or developed their terms of reference during 2013. We are advocating the use of the term 'Quality and Safety' rather than the more traditional term 'Clinical Governance' in the committee titles at three levels, as follows: (i) Quality and Safety Board Committee (ii) Quality and Safety Executive Committee and (iii) Quality and Safety Directorate Committee/Quality and Safety Specialty Committee.

Quality and Safety Audits

Quality and Patient Safety audits were commissioned (i) of a sample of Quality and Safety Committees within acute, mental health, primary care and social care services; and (i) accountability arrangements for quality and safety in a sample of acute hospitals. The audit findings will be available in Q1 2015.

Board on Board Quality Improvement Project

In January 2014 we collaborated with the Mater Misercordiae University Hospital for a year long Board on Board Quality Improvement Project. This was supported by a project group composed of Mater staff with expertise in clinical care and measurement, together with two QPSD staff undertaking a QI fellowship with Scottish Patient Safety Programme. The aim of the 'Mater Board on Board' Quality Improvement (QI) Project was that the Board of Directors of Mater individually and collectively, (i) get a comprehensive *picture* of the quality of clinical care, (ii) have an *understanding* of same, and (iii) *act* to hold the hospital accountable on the quality of clinical care delivered. Over the year ten new resources were developed and tested with the board including a *Board of Directors' Quality Dashboard* and the use of the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool. Phase one of this quality improvement project completed in December

2014 and a case study report will be available in early 2015. A poster of the Board on Board QI project has been accepted for presentation at International Quality Forum in April 2015.

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 2014 the programme has delivered tangible benefits to services across the following areas of work.

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

Guidance on Clinical ownership, Handover/Handback, of patients for unscheduled care.

Clinical resource to HSE at LRC and on site validation visits during NCHD industrial dispute.

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

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

Healthcare Acquired Infection (HCAI

Antimicrobial Resistance (AMR) National Clinical Programme

HCAI AMR Clinical Programme Update 2014

Programme Manager: Roisin Breen
Clinical Lead: Dr Rob Cunney October 2014 to date
Clincial Lead: Dr Fidelma Fitzpatrick end of september 2014

1. Communication:
The HSE and RCPI websites include information for staff and the general public:

- http://www.hse.ie/hcai
- http://www.hse.ie/antibiotics

- http://www.hse.ie/handhygiene
- http://www.rcpi.ie/article.php?locID=1.5.257.499
- http://www.undertheweather.ie (Launched to ensure people, particularly mums and young families are supported to look after themselves at home if they have a cold/ flu and to reinforce the message that you do not need an antibiotic from a range of day to day illnesses)

Hand Hygiene

Education and training

- Ongoing biannual education for lead hand hygiene auditors in acute hospitals.
- WHO Hand Hygiene Day 2013 marked with newsletter, lectures at ICGP summer school, article in Health Matters magazine,article in ICGP HCAI AMR newletter, emails to all HSE staff and poster campaign
- Hand hygiene video on 5 moments – hospitals and primary care http://www.hse.ie/go/handhygiene
- Hand hygiene website developed: www.HSE.ie/go/handhygiene

Hand hygiene guidelines

- 2005 Hand Hygiene Guidelines being updated in line with WHO guidelines
- A hand hygiene audit software tool is operational in conjunction with HPSC
- National alcohol hand gel specification completed: http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/Handwashing/Publications/.

Data reporting (hospitals)

- Hand hygiene education of healthcare staff – commenced April 2014
- Hand hygiene audit complicance[1] and Alcohol hand gel consumption[2]

SAVING LIVES IT'S IN YOUR HANDS

2.1.2 RCPI hand hygiene steering group

- Designed and delivered a new campaign aimed at improving medical staff hand hygiene https://www.youtube.com/watch?v=e-xwv4Yz57c
- Over 200 Trainees, Members and Fellows took part in the survey.
- Competition among fellows, members and trainees to develop hand hygiene campaign slogan.
- Hand Hygiene fact cards were produced and circulated at all RCPI trainee and member events.
- Dr Colm Henry, National Lead for the Clinical Director Programme, is clinical ambassador for the campaign: https://www.youtube.com/watch?v=e-xwv4Yz57c

2.2 Antibiotic Stewardship

Education and training

- European Antibiotic Awareness Day (EAAD) was held 20th November 2014 including a launch and CPD event

Public Engagement:

- New videos on antibiotics and AMR and Update of HSE antibiotic homepage for EAAD
- Prescriber education

    - RCPI e-learning module for hospital prescribers
    - RCPI focus on delivering antimicrobial stewardship educational material (to commence at EAAD 2014)
    - ICGP meetings
    - RCPI and ICGP e-zines
- Improved public information on antimicrobials and AMR – www.hse.ie/antibiotics, www.hse.ie/hcai. Launched www.undertheweather.ie in October 2014
- Public information campaign -Good bugs, bad bugs and super bugs - Protecting you and your family from infection

Guidelines

- MRSA –endorsed by the National Clinical Effectiveness Committee, launched by the Minister of Health, Dr. James Reilly, December 2013
- Primary Care Antibiotic Guidelines updated regularly (smartphone/tablet format). www.antibioticprescribing.ie
- HSE A-Z updated with info leaflets on common conditions. http://www.hse.ie/eng/health/az/
- Care bundles for hospital prescribers - 'Start smart then focus' and 'Right Drug, Right time, Right Duration' http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/CareBundles/
- Dental guidelines for incorporation into primary care antibiotic guidelines
- Update of guidelines on screening for CRE in Ireland

Data reporting

- Since April 2014, monthly indicators are being reported from all acute hosptials:
    - Hospital acquired *S. aureus* bloodstream infection/10,000 BDU
    - Hospital acquired new cases of *C. difficile* infection/10,000 BDU
    - Hand hygiene training compliance
- Pilot study on developing feedback for GPs on antibiotic prescribing and AMR in conjunction with the ICGP, NUI Galway, Irish Society of Clinical Microbiologists and HPSC.

Guidelines for the Prevention and Control of Multi-drug Resistant Organisms (MDRO) excluding MRSA in the Healthcare Setting.

- Reviewed and updated the 2013 guidelines on screening for carriage of resistant E*nterobacteriaceae*.
- The MDRO committee will continue to review the national screening recommendations on a regular basis. http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Guidelines/File,12922,en.pdf

European Point Prevalence Survey of Healthcare-Associated Infections in Long-Term Care Facilities (HALT)

- The national HALT report as collated end 2013 – early 2014 and is available at: http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Surveillance/HCAIinlongtermcarefacilities/HALTReports/2013Report/National2013HALTReport/File,14540,en.pdf
- Separate reports were collated for different LTC facilities: http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Surveillance/HCAIinlongtermcarefacilities/HALTReports/2013Report/National2013HALTReport/ All participating facilities received a local HALT report for local feedback and action plans.

Update of 2009 National Guidelines for the Prevention of Intravascular (IV) Catheter Infection

This partial update of the 2009 guidelines focused on the prevention of IV catheter infection and incorporated aspects of recent publications that are acknowledged as the most authoritative reference guidelines currently available. The guidelines will be available in early Q4 on the HPSC website.

2.6 Gentamicin collaborative:

- A project based on improving the usage of gentamicin in a number of hospitals started in 2013. The project was initiated in conjunction with the National Quality Improvement (QI) Programme. The group devised and tested a series of improvements to try to identify how to effectively and efficiently prescribe and monitor gentamicin usage across a variety of settings.

2.7. Primary Care

Work of the Primary care subgroup can be seen in all other subgroup sections in addition other work includes:

- Ensuting online access to antibiotics guidelines and other tools in OHH centres
- Survey of single use disposable items and hand hygiene facilities planned through Primare Care division
- Infection prevention and control foundation course UCC September 2014
- Infection prevention and control guidelines published on ICGP and HSE websites http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Guidelines/File,14612,en.pdf
- ICGPRN - pilot in Galway to improve antibiotic prescribing in UTI, development of a urinary resistance data tool and antibiotic prescribing audit tool has been completed.

2.8: Intersectoral AMR:

- Ongoing collaboration with DOH and DOA on advancing intersectoral AMR

Quality Assurance

Quality and Patient Safety Audit

Twelve audits were completed in 2012 Audits covering incident management and investigation, dementia care, ambulance services, intellectual disabilities, records management, nursing, and implementation early warning score.

Six audits were in progress at year end. Audit areas include nurse prescribing, accountability arrangements for quality and patient safety, exposure to radiation, and services in Aras Attracta (disability residential services).

Raising Concerns

We are currently working with HR to integrate. update, make user friendly, publish and communicate the Protected Disclosure and Good faith process for those who wish to 'Raise and report a concern' This will also be integrated with the new 'confidential Recipient', as an alternative option for reporting.

Audit recommendations tracking

As part of our end of year reporting, a review is now being conducted on audits completed between June 2013 and June 2014 to ascertain the status of the implementation of QPSA recommendations. 78 recommendations are being tracked as part of this process.

National Directors / service managers have been requested to advise on recommendation implementation and evidence of service improvements based on the recommendations of audits. A report will be completed from this and circulated to senior management and the HSE Risk Committee. Learning from this review will provide valuable information which will contribute to intelligence on performance analysis, trending, and measuring quality improvements.

This will also be part of the the National Performance Oversight Group process.

QID / Social Care Quality Improvement Enablement

In July and December 2014, a QID service improvement team supported the Social Care Division in the assessment of the implementation of quality standards in practice in the Aras Attracta residential service for adults with intellectual disabilities. In collaboration with service users and staff. QID assisted senior management in developing a plan to support the service to address immediate concerns regarding care and to support a culture that places the needs and dignity of service users at the centre of service provision.

QID is now supporting the Social Care Division in extending the initial work commenced in Aras Attracta to other residential services for adults with intellectual disabilities. This project represents a partnership between the Social Care Division and Quality Improvement Division (QID) and SCD-Disability Services are jointly providing resources to form interdisciplinary SCD/ QID Quality Improvement Enablement project Teams, combining extensive knowledge and competencies in the areas of audit and evaluation, quality improvement, disability services and clinical expertise.

The aim of this project is to work with residential services for adults with intellectual disabilities to advise and support them to improve the delivery of quality and safe person-centred services. In Phase One of this project, which will commence in Q1 2015. SCD/ QID Quality Improvement Enablement teams will:

1. Work with residential services on their existing HIQA self-assessments and QIPs to enable them to address HIQA National Standards for Residential Services (2013) within scope of this Project
2. Give residential services support and advice on how to address issues identified during the course of the service visits, as they relate to quality of care
3. Advise Disability Services on how to source local, relevant ans specific supports to enable them to deliver on the implementation of their Q1 plan and projects e.g. training/ mentoring
4. Assist Disability Services in identifying and sharing national and local learning arising from the Project

Quality Indicators /Quality Profile

Ten indicators were chosen by the National Quality and Safety Indicator Committee established by Dr Philip Crowley, which met over the course of 2013. The indicators were based on a review of the literature on best international evidence. A number of the indicators are based on OECD Patient Safety Indicators or Australian Patient Safety Indicators. The committee undertook a development and validation process to ensure that a standardised

approach to data definitions and minimum data set were applied.

In June 2014, the Quality and Patient Safety Working Group was established to pilot these indicators and test their sensitivity and specificity. In addition, the Working Group were to assess the reliability and validity of the HIPE system for these indicators. The group agreed to undertake a two phase process, testing the first five (post operative wound dehiscence, foreign body left in during procedure, haemolytic transfusion reaction, in-hospital fractures and accidental puncture or laceration) and, depending on results and decisions, proceed to testing the remaining five indicators. The Working group noted that data on a national level has already been provided to the OECD by the Department of Health for 2 of the Indicators, 'foreign body left during procedure' and 'post operative wound dehiscence', and therefore is publicly available on the OECD website.

Following discussions, the Working Group decided to exclude paediatric and neonatal cases from the QPS Indicators list. The rationale for this decision came from the OECD removing 'cases aged 0 – 14' from their specifications and paediatric hospitals advising that on review of the indicators they were found not to fit well in the paediatric population. However, the Working Group is committed to supporting the development of Paediatric and Neonatal Indicators and will work with relevant parties to progress this.

A quality profile is a comprehensive, timely and reliable report that describes the quality and safety of the healthcare provided within a service. It is a tool that brings together relevant information for the senior most accountable manager to help answer whether high quality patient care is being provided, and if not, to identify areas for quality improvement activities.

In September, 2014, the quality profile steering committee met for the first time. Following the initial meeting, the scope of the quality profile project was agreed. A framework document describing some of the key principles underpinning the development of a quality profile was prepared. The planning also began for individual pilot sites to commence in early 2015 with a view to demonstrating how a service would develop a quality profile.

Guidance and Support for Quality and Patient Safety Processes

National Consent Policy

In Q1 and Q2 a number of consultation sessions were held with services, Colleges, and Regulators to inform a consent training programme. From these a series of train the trainer sessions were held where staff we enabled to provide training locally. Training packs including workbooks and DVDs were provided.

Integrated Discharge Planning

Revised guidance was completed following a series of consultation exercises with all relevant stakeholders. The guidance was published in Q1, 2014.

Patient Safety Culture Survey

The National Patient Safety Culture Survey was the first undertaken by the HSE to establish current views of staff on patient safety within their organisations. Following the pilot in 2012, further refinements were made, following which the survey was rolled out as a national project in 2013. In order to facilitate hospitals as much as possible, it was necessary to divide this national project up into five phases, which commenced in June 2013 and continued through to March 2014.

Each participating hospital received its own survey report. This assessment of a hospital's patient safety culture should assist the hospital in meeting the National Standards for Safer Better Healthcare (HIQA 2012) and enable the hospital to incorporate its survey findings into any quality improvement plans being developed to meet the requirements of the National Standards for Safer Better Healthcare.

In order to meet further information requirements, data from 41 participating hospitals and 4,700 respondents, were merged into one composite database and analysed. The Composite Results and Comparative Statistics Report presents this analysis in the form of overall results and comparative measures so as to enable each hospital to compare its results with those of other hospitals.

Decontamination

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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 continued to oversee the management of serious incidents and also continued to support the training of management teams to manage and investigate their own cases more effectively. However, 2014 saw the handover of the management of incidents by the NIMT to direct oversight/management by each of the Divisions. Within this process the formation of the Transition Incident Management and Learning Team (TIMLT) took place.

The updated version of the Safety Incident Management Policy was published in May 2014.

http://hsenet.hse.ie/Who/qualityandpatientsafety/incidentrisk/Riskmanagement/SafetyIncidentMgtPolicy2014.pdf?

Serious Reportable Events

Following the publication of the Report on Maternity Services in Portlaoise in early 2014, the Chief Medical Officer of the Department of Health requested the reporting of all incidents that result in death or serious harm. This is in line with the recommendations of the 2010 Report *'Learning for Safety'* and subsequently with the HSE's Safety Incident Management policy (2014). A national Serious Reportable Events group was established and chaired by Dr Philip Crowley in early 2014 with key internal and external stakeholders (DOH and appropriate training Bodies) to oversee an annual review of the list. The list was finalised and issued in January 2015.

Protection of Life During Pregnancy Act 2013 (POLDPA)

The enactment of the above legislation took place with effect from 01 January, 2014. The National Director of QPS has the responsibility for the administration of its provisions.

In July 2014 a high profile case concerning the POLDPA occurred. This resulted in the commissioning of a report by the Director General to establish the facts surrounding the case and this was chaired by the National Director of QPS. However the Report process was paused in October, prior to its completion for reasons relating to the health status of the service user at the centre of this Report.

Supporting Care Improvements in Residential Disability Care Settings

The Quality Improvement Division of the HSE has been supporting the Social Care Division in the evaluating the quality and standards of care provided in the Aras Attracta Service commencing at the end of 2014 and continuing into January 2015. In collaboration with clients and staff a plan has been developed to support the services to address immediate concerns regarding care and to support the development of a culture that places the needs and dignity of clients at the centre of service provision.

This work has now been completed in Aras Attracta and improvement plans have been put in place. The improvement project will now be extended nationally to all residential disability sites commencing initially in HSE sites. This is in line with the priorities outlined by the Task Force on Disabilities which was established by the HSE in December 2013. The project will be undertaken in a number of phases over a two year period.

Key priorities for 2015

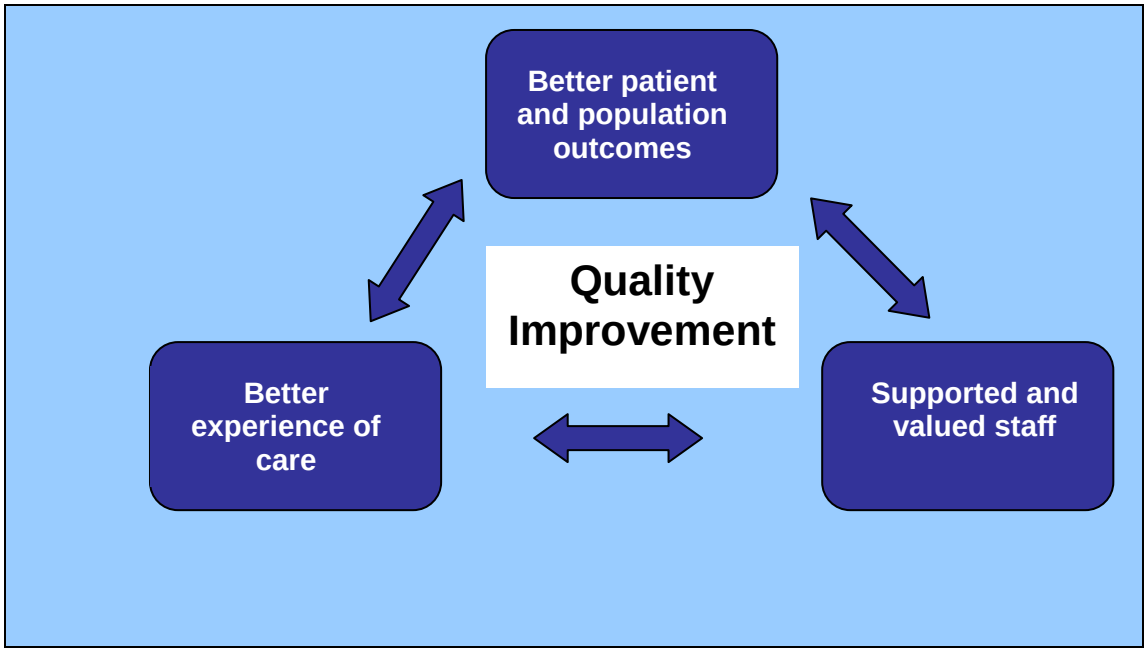
The aim and strategic objectives of the QID are:

Aim: To support the development of a culture within our healthcare system that ensures improvement of quality of care is the primary focus throughout all services.

Strategic objectives:

1. To support leadership to prioritise and drive quality of care in all services
2. To influence and support the structures, processes and oversight (governance) for quality and safety
3. To support a culture where patients, families and communities are listened to, empowered and enabled to share decisions relating to their care and are continually involved in the design and delivery of equitable services.
4. To create an environment which values staff by listening, empowering and enabling them to continuously improve the care they provide.
5. To influence and support the selection, promotion and development of key improvement methods for use across services.
6. To enable the transparent use of data on quality of care by services to provide information for learning and improvement.
7. To develop and support the delivery of key safety programmes.

Improving quality within healthcare seeks better outcomes for service users, better experience of care (system performance) and the continued development and supporting of staff in delivering quality care.



Contribution from staff:

The progress made in 2014 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 2014 demonstrate that this responsibility is put into practice by many people across the HSE.