



# Patient Safety Strategy 2019-2024





**ISBN No:** 978-1-78602-127-4

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# Foreword: Chairperson, HSE Board and CEO, HSE

Keeping patients and those who use our services safe is the overriding priority for those of us working in, or overseeing the work of the health service.

National and international evidence however shows us that as many as 1 in 8 patients suffer harm while using healthcare services and up to 70% of this harm could have been prevented. This is not acceptable and we must make every effort to reduce these devastating statistics that take such a human toll. It is for this reason that the development and implementation of the first overarching **Patient Safety Strategy 2019-2024** for the health service is a priority for the newly established Board of the HSE.

The Board of the HSE, together with its Safety and Quality Committee and the HSE's Executive Management Team, acknowledges that many excellent patient safety initiatives have been implemented in recent years resulting in measureable improvements. Many of these have been taken in response to serious patient safety incidents.

The development of the Strategy builds on this and is an important example of how real and meaningful partnerships between patients and those working at each level of the health service can generate a shared vision for a more compassionate health service, one that learns when things go wrong, responds accordingly and reduces harm to those who entrust their lives and care to us.

Our vision for patient safety is that **all patients using our health and social care services will consistently receive the safest care possible**. Nurturing a culture of patient safety which places emphasis on a culture of transparency and organisational learning is key to this. This must be supported by meaningful involvement of patients and staff, effective governance and leadership and a commitment to enhancing our safety capability, including embracing safety science, in order to design safe systems of care.

In this Strategy we make 6 Commitments. We will:

- **Empower and Engage Patients to Improve Patient Safety**
- **Empower Staff to Improve Patient Safety**
- **Anticipate and Respond to risks to Patient Safety**
- **Reduce Common Causes of Harm**
- **Measure and Learn to Improve Patient Safety**
- **Provide effective Leadership and Governance to Improve Patient Safety**

We will also continue to build on frameworks such as the HSE's **People Strategy**, the **Framework for Improving Quality (2016)**, **Incident Management Framework (2018)**, our framework for change **People's Needs Defining Change (HSE 2018)** and the **National Standards for Safer Better Healthcare (HIQA 2012)**.

Critically, the Patient Safety Strategy will align closely with the implementation of **Sláintecare**, the blueprint for the reform and development of our health services over the next decade and beyond.

**Effective implementation is the real test of any strategy.** The HSE's National Service Plan 2019 commits us to putting in place new governance arrangements to support and oversee implementation of the Strategy and the further development of targeted patient safety initiatives. A National Patient Safety Programme has been established, which will oversee and monitor the implementation of this Strategy. Implementation will involve a partnership with patients, staff and other bodies such as the Department of Health, the Health Information and Quality Authority [HIQA], the Mental Health Commission, the State Claims Agency and the Professional Bodies.

Patient Safety is everyone's business and we must all play our part in making our health and social care services safer for everyone. This Strategy is for us all.



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**Ciarán Devane,**  
*Chairperson, HSE Board*



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**Paul Reid,**  
*Chief Executive Officer, HSE*

# Foreword: Chairperson, Patients for Patient Safety Ireland

Over the course of a human life very few of us will escape the experience of being a patient or health care service user. When we find ourselves in that vulnerable position we need to believe that our health care system is there to support our needs, delivering safe compassionate care to achieve the best possible outcome.

No healthcare system is risk free as it is full of unpredictable challenges and involves human skill and judgement and the input of many stakeholders. It also requires a vision of how these stakeholders work together. The delivery of services requires people and our health service is a significant employer. It has a duty of care to its employees, a duty to support them in their work to enable them to deliver the best care in an appropriate environment, with realistic patient staff ratios.

Preventable adverse events have the most devastating impact when a patient suffers unintended consequences, life altering impairment or dies. These consequences need to be acknowledged, processed and used in a meaningful way to promote better outcomes with appropriate supports offered to everyone involved. Such occurrences should never be dismissed as bad luck.

To be bereaved as a result of a loved one's misadventure within the healthcare system leaves an additional layer of grief. That life mattered, the loss of that life needs to matter, and learning needs to come from that loss. Often harm is predictable, avoidable and therefore improvements to eliminate the causes are achievable. We hear about adverse incidents too often; they undermine public confidence, frighten patients, demoralise staff, and both burden and shame the healthcare industry.

The Patient Safety Strategy is a meaningful collaboration between the health service, staff and patients, all working towards safer care. It is inclusive, capturing the opinions of everyone and reflecting what we would all like to see – our health service always giving the best care to those who need it.

I believe change happens when visions becomes actions. I welcome the vision of the Patient Safety Strategy and I very much look forward seeing its actions and objectives achieved through full implementation.



**Bernie O'Reilly,**

*Chairperson, Patients for Patient Safety Ireland*

## Introduction

# What is Patient Safety?

Patient safety can, at its simplest, be defined as: The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare. (Charles Vincent, 2006<sup>1</sup>)



## Why focus on Patient Safety?

During our lifetimes, each of us will at some stage be a patient or will be a user of our health and social care services. We will expect the safest and best care possible, placing our trust in professionals to improve our health or provide a service that will support us in living fulfilled lives. Maintaining the highest levels of patient safety is a fundamental priority for patients and for healthcare organisations.

### PREVENTABLE HARM

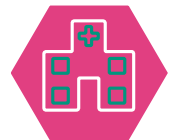
**17%**

of all hospitalisations are affected by one or more adverse events, with 30-70% potentially preventable.<sup>(2,3)</sup>



The 2009 Irish National Adverse Event Study indicated that an **adverse event** occurred in approximately **1 in 8** acute hospital admissions<sup>(3)</sup>

### PREVENTABLE DEATH



In the UK an estimated **5.2%** of adverse events resulted in Patient Death.<sup>(4)</sup>



**PATIENT HARM** estimated as **14th LEADING CAUSE** of global **DISEASE BURDEN**<sup>(5)</sup>

**15%** of **HOSPITAL EXPENDITURE** in OECD attributed to **TREATING SAFETY FAILURES**<sup>(6)</sup>

Total cost of clinical claims in **2010-2018** was **€1391.8 million**<sup>(6)</sup>

## Patient Safety must be Everyone's Business!

Throughout the Strategy the term "we will" means that actions will be developed and implemented at every level of our health and social care services, within both community and acute hospital services, to improve patient safety.



In addition, in the context of this Strategy, the term 'Patient' is intended to include all people who attend/ use our health and social care services; "Staff" refers to all Healthcare Professionals, Clinicians, Support Workers, Managers and Administration Staff who all have a role to play in making our health systems safer.

# A Health Service Movement for Patient Safety

## Our Implementation Philosophy: Supporting Front Line Action for Patient Safety

Continuing improvements in healthcare and health outcomes come at a time when the way in which healthcare is delivered is becoming increasingly complex. Complexity always creates more potential for risk, and this includes risks to the safety of those who use our services.

At the frontline of our healthcare services our staff, including nurses and doctors are providing quality care that is safe. They are leading practices of care and initiatives to make that care even safer. Nationally the HSE is seeking to support them in this work. In recent years, a large number of initiatives have been taken. These include:

- *33 National Clinical Programmes which continue to improve how care is delivered;*
- *Ireland was the first country in the world to introduce a National Clinical Guideline for a National Early Warning Score (NEWS);*
- *Sepsis associated hospital deaths falling by 30% over the past five years;*
- *A 49% reduction in ward acquired pressure ulcers across the 23 participating teams through the Pressure Ulcers to Zero (PUTZ) campaign;*
- *Major action to address healthcare associated infection rates; and*
- *Improvements are being made in response to the annual National Patient Experience Survey.*

This Patient Safety Strategy therefore recognises the significant action already taken and seeks to build on and support this work through:

**Strategy Commitments:** The six commitments set out in the Strategy serve as a health service Charter for Patient Safety. We aim to embed these commitments at every level of the health service so that they serve as a basis for building a movement for patient safety.

**Strategy Actions:** Each commitment comes with a set of associated actions. These actions are designed for adoption by local services as part of their local plans. They recognise the significant work already being taken and they will be supported by the HSE nationally.

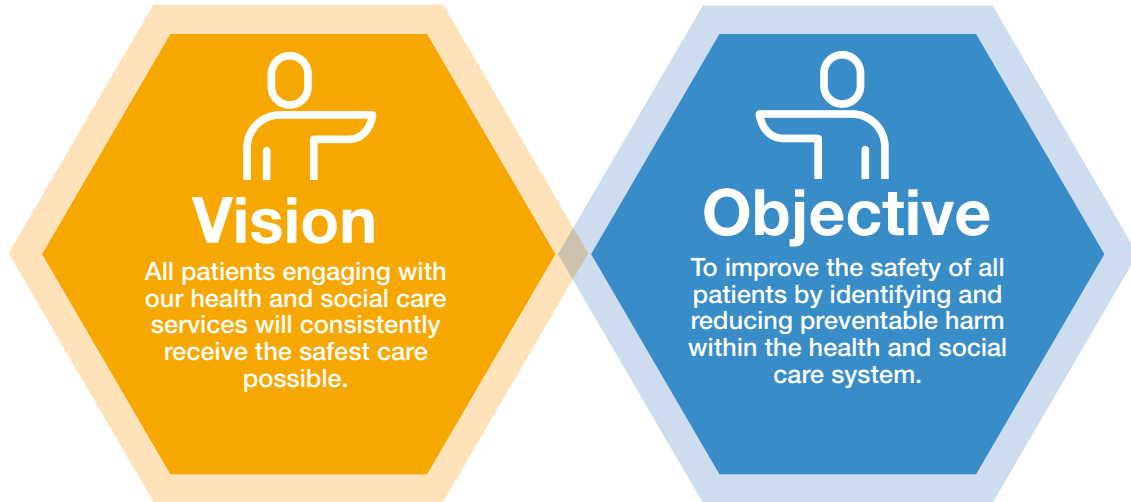
It is the vision of the Patient Safety Strategy that all patients will consistently receive the safest care possible. This care is provided best by staff who feel engaged and valued, are emotionally connected to and are fully involved in and enthusiastic about their work. The health service workforce is deeply committed to providing an excellent service and when fully engaged we know that what we do and say matters and makes a difference. An engaged workforce is also linked to reductions in the number of safety incidents and improved clinical care. It is for these reasons that staff engagement is a key driver of the HSE Framework for Improving Quality and the HSE's People Strategy.

The Strategy also recognises that patients are the best advocates for and often best placed to inform and support safety improvement. That is why the Strategy places a significant emphasis on them being central to the planning and implementation of the Strategy.

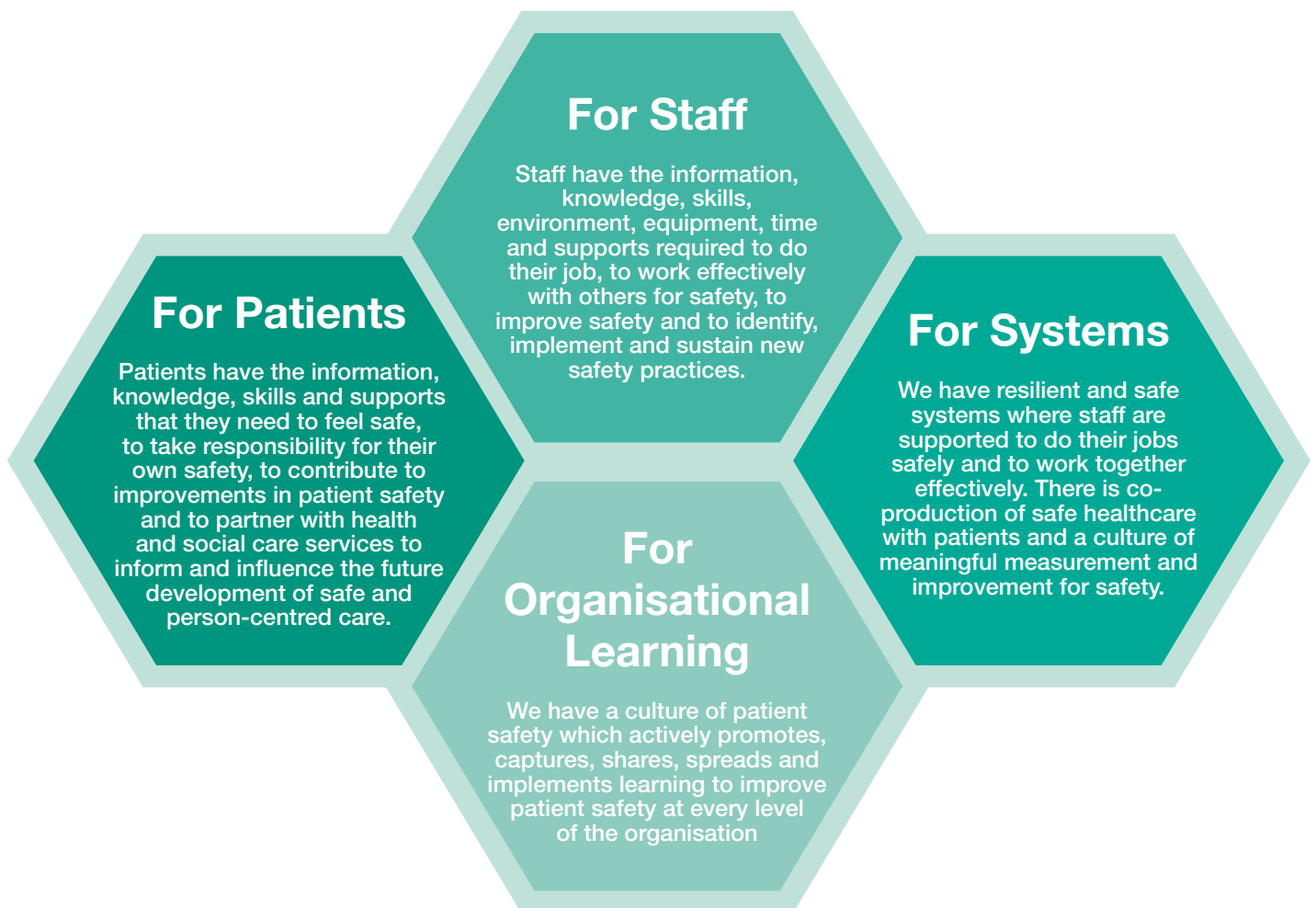
The Patient Safety Strategy has therefore been developed primarily to guide further safety improvements at service level. It is recognised that this change cannot be centrally or nationally implemented. It can however be supported nationally. The HSE is committed to ensuring its national level resources are aligned to supporting continued local action for patient safety.



# Patient Safety Strategy: Our Vision, Objective and Ambitions for Patient Safety



## Our Ambitions for Patient Safety<sup>1</sup>



<sup>1</sup> See Appendix 1 for a full description of our Patient Safety Ambitions.

# Patient Safety Strategy: Our Commitments to Patient Safety

The vision and objective of the Patient Safety Strategy will be supported through the achievement of the 6 strategic commitments set out below.

## Patient Safety Commitments:

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1

### **Empowering and Engaging Patients to Improve Patient Safety**

We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care.

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2

### **Empowering and Engaging Staff to Improve Patient Safety**

We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety.

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3

### **Anticipating and Responding to Risks to Patient Safety**

We will place an increased emphasis on proactively identifying risks to patient safety to create and maintain safe and resilient systems of care, designed to reduce adverse events and improve outcomes.

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4

### **Reducing Common Causes of Harm**

We will undertake to reduce patient harm, with particular focus on the most common causes of harm.

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5

### **Using Information to Improve Patient Safety**

We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety

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6

### **Leadership and Governance to Improve Patient Safety**

We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance.



# 1

## Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care.

### Rationale

Key to patient safety and person-centred care is a culture where patients, carers<sup>2</sup>, families, advocates and health care professionals work together in partnership to ensure positive patient experiences, maximise positive health outcomes and minimise the risk of error and harm. The goal is to achieve a culture that welcomes authentic patient-partnership in their care and in the process of co-producing, delivering and improving care.

#### Patient Safety Principle

Patients are supported with the knowledge, skills and supports that they need to take responsibility for improving their own safety in partnership with staff. Patients, families, carers and advocates are listened to and actively involved in making our services safer.

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<sup>2</sup> A carer is described as someone who is providing an on-going significant level of care to a person who is in need of care in the home due to illness or disability or frailty. This includes Family Carers.

# Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

## Actions

- 1.1 We will foster a culture and practices in which **patients are fully informed and engaged** in decisions about their care and are facilitated to best support their own safety.
- 1.2 We will implement initiatives so that patients will have the required **skills, information and knowledge** about their condition, complex care needs and treatment options.
- 1.3 In partnership with patients, we will continue to develop mechanisms to **empower patients to contribute to the safety of health and social care services**. This will include their involvement as partners in key governance structures and processes.
- 1.4 We will continue to participate in the **National Care Experience Programme** and associated experience surveys to enhance the ability of the health and social care services to **listen to and act on the voice of patients**.
- 1.5 We will develop **resources and supports with patients** that draw on their experiences and expert knowledge.
- 1.6 We will identify and address the **training and information needs** of patients, families, carers, patient representatives and advocates to enable them **to contribute to preventing harm and improving patient safety** including reporting incidents and patient safety issues.
- 1.7 We will **strengthen our partnerships with patient representative groups** and, in particular, with those groups that focus on patient safety improvement such as the WHO's Patients for Patient Safety Ireland. We will inform patients about partnerships at local and national level and how to be involved.
- 1.8 We will develop a **national function reporting to the Chief Clinical Officer** with particular responsibility for enhancing our approach to meaningful partnerships with patients.
- 1.9 We will further **embed a culture where we acknowledge when things go wrong, offer meaningful apologies, and act to put things right** through the implementation of relevant legislative provisions and policies in relation to Patient Safety and Open Disclosure<sup>3</sup>.
- 1.10 We will **support patients and families following an adverse event** through open communication and engagement, understanding what went wrong and the identification of measures to reduce the recurrence of the preventable causes of harm.
- 1.11 We **acknowledge the psychological distress** caused to patients and families when adverse events occur and we will further develop resources and supports in this area.

3 Including the Patient Safety Bill (2018) and the Civil Liability (Amendment) Act (2017).

# 2

## **Commitment 2: Empowering and Engaging Staff to Improve Patient Safety**

We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety.

### **Rationale**

Creating and maintaining a positive safety culture and designing safe systems of care is central to the mission of our health and social care services. It is a culture where safety is seen as an organisational-wide priority, there is learning from failures and successes, there is an understanding of the current climate and its challenges and meaningful actions for improvement are implemented. Staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in safety improvement initiatives.

### **Patient Safety Principle**

Health and social care service staff will understand the importance of patient safety and the contribution they can make to ensuring safe care is provided. They will be supported to deliver care safely and reliably, to be sensitive to the situations within which they work and to respond with transparency, openness and compassion to harm events when they occur.

## Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

### Actions

- 2.1 We will **support staff to deliver safe, high quality care** by ensuring their work environment and health care structures and processes are designed and managed to facilitate safe practice.
- 2.2 We will facilitate and co-ordinate efforts to **assess, plan and manage workforce and resource requirements**, using risk based prioritisation, to ensure safe systems of work and safe staffing levels that support improvements to patient safety.
- 2.3 Systems and processes will be further developed to **ensure that staff are effectively listened to, communicated with and are fully involved and engaged** in the planning and delivery of the services they provide and that they are supported and facilitated to raise safety concerns and improve patient safety.
- 2.4 We will **enhance the capacity and capability of health and social care services and staff to improve patient safety** by designing and delivering safety information and training to include patient safety and reliability science, systems thinking, audit, quality improvement methodologies, change management, human factors and multidisciplinary team working for safety.
- 2.5 In partnership with staff and training bodies, we will develop strategies to **promote behaviours that support a culture of safety** including collective leadership, communication and multidisciplinary team working. This will include strategies that enhance situational awareness, for example 'safety pauses' for teams.
- 2.6 We will facilitate the continued **coordination, networking, sharing and learning for patient safety** amongst patient safety leaders, staff, health care providers and external agencies such as the Health Information and Quality Authority, Mental Health Commission, Health and Safety Authority and State Claims Agency.
- 2.7 We will continue to support staff in **reporting and learning from incidents** and implement strategies to enhance and improve incident reporting and reviews.
- 2.8 We will improve and develop **supports (including psychological support) and care for staff** affected by serious patient safety incidents.
- 2.9 We will continue to **support programmes promoting a patient safety culture and person-centredness.**<sup>4</sup>
- 2.10 We will **measure the culture of patient safety** across health and social care services and identify and implement actions to address identified deficits.

4 For example: Values in Action Programme, Staff Health and Wellbeing Programme, the National Healthcare Communication Programme and the National Programme to Enable Cultures of Person-centredness.

# 3

## Commitment 3: Anticipating and Responding to Risks to Patient Safety

We will place an increased emphasis on proactively identifying risks to patient safety to create and maintain safe and resilient systems of care, designed to reduce adverse events and improve outcomes.

### Rationale

Anticipating risks before they occur and acting to address these risks, will allow us to keep the people who use our services safer, will provide better outcomes for patients and staff and will help develop trust and confidence in health and social care services. Key to this is supporting services to change the way they handle safety, by moving from a reactive and incident-based approach to a more proactive and risk mitigation-based one.

### Patient Safety Principle

Health and social care services will be trusted by patients to identify and manage risks to their safety, learn from things that go wrong, learn from examples of good practice and show measureable progress in reducing levels of preventable harm.



## Commitment 3: Anticipating and Responding to Risks to Patient Safety

### Actions

- 3.1** **Governance arrangements for the management of risk** will be closely integrated into the organisation's overall management processes.
- 3.2** **Addressing risks to patient safety** will be a priority area of focus in all health and social care service strategic planning and commissioning.
- 3.3** Key **strategic and policy decisions** taken by management teams will be **routinely risk assessed** so that unintended consequences that might impact on patient safety are avoided.
- 3.4** We will **change the way services address safety risks**, from the prevailing reactive and incident-based approach, to a more proactive and risk mitigation-based one.
- 3.5** We will put in place **systems to continuously improve the quality and analysis of patient safety data and intelligence** to allow us assess risks to patient safety. We will then put in place appropriate actions to mitigate identified risks, including building the response to these risks into planning and resource allocation decisions.
- 3.6** We will improve the **quality and timeliness of incident reviews** and **ensure that learning** from the review of incidents is optimised and routinely used to inform system change and the development of safety programmes.
- 3.7** We will put in place formal processes for the **communication of risk** in line with the organisation's accountability arrangements.
- 3.8** We will **integrate patient safety information and data** to allow us to analyse the reliability of health and social care processes, proactively identify areas of risk to patient safety, and learn from where things go wrong and from examples of good practice in a way that will inform safety improvement programmes.
- 3.9** We will **publish data** in relation to patient safety across the health and social care system.
- 3.10** We will seek to put in place resourcing for the full **implementation of National Clinical Guidelines** produced by the National Clinical Effectiveness Committee.
- 3.11** We will strengthen **clinical audit structures and processes** to improve both patient outcomes and safety outcomes within our health and social care services.

# 4

## Commitment 4: Reducing Common Causes of Harm

We will undertake to reduce patient harm, with particular focus on the most common causes of harm

### Rationale

International evidence indicates a number of high impact patient safety risks which, if tackled effectively, can result in improving safety in healthcare organisations<sup>(7-12)</sup>.

#### Patient Safety Principle

Health and social care services will implement best practices for patient safety, incorporating safety improvement methodologies, to achieve a measurable reduction in patient harm in prioritised safety areas.

### Patient Safety Improvement Priorities:



5 We recognise that there may be additional safety or safeguarding risks for people with a disability and/or mental healthcare needs attending health and social care services.

6 For example Emergency and Out of Hours Care, Surgery and ICU.

## Commitment 4: Reducing Common Causes of Harm

### Actions

- 4.1 We will put in place **integrated governance structures with clear accountability** for planning, managing and addressing the above patient safety priorities.
- 4.2 We will develop **implementation plans and prioritise initiatives** to address these and other emerging priorities for patient safety improvement as part of our annual and multi annual planning process over the course of the Strategy's lifetime.
- 4.3 Through the **National Patient Safety Programme** (recommendation 6.2) **we will monitor the implementation plans** for the prioritised patient safety initiatives and the attainment of patient safety improvements.
- 4.4 We will constantly **monitor and review patient safety risks** and will prioritise **other patient safety and improvement initiatives** where this is required.
- 4.5 We will include **patient safety as a key objective** in any current or newly established **programme, strategy, policy or project** across health and social care services.
- 4.6 We will **align current specialist resources at national level** within the HSE to support the priorities set out in the Strategy.

# 5

## **Commitment 5: Using Information to Improve Patient Safety**

We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety

### **Rationale**

The measurement of patient safety is complex. To make health and social care safer, organisations must be transparent and open, continually measuring harm and reliability, recognising and learning from good practice, assessing standards of care and targeting programmes of improvement. They must also remain alert to problems and changes as they occur and be adept at responding to and managing potential threats to safety.

### **Patient Safety Principle**

There is an ability to learn and improve across the whole health and social care service. Patients, carers, families, health service leaders and staff will know that services are safe based on reliable information. They will know too that incidents will be quickly identified and responded to, ensuring continuous learning and improvement in safety.

## Commitment 5: Using Information to Improve Patient Safety

### Actions

- 5.1 We will further develop and enhance local and national suites of key **patient safety indicators** which will be used as part of the health and social care services' performance and accountability process.
- 5.2 We will **measure and monitor safety** to evaluate the effects of safety improvement initiatives and to inform further emerging priorities.
- 5.3 We will develop, consolidate and continuously improve **patient safety surveillance and reporting systems** at every level of the health and social care service.
- 5.4 We will use a range of **information sources and methods of presenting data**, including incident and risk data, quality and safety metrics for clinical services, assessments against national standards, patient engagement, staff engagement, claims, complaints, incident reviews, clinical audit, regulatory reports, Coroner's reports, mortality reviews and research to support these patient safety surveillance and reporting systems.
- 5.5 We will **publish reports in relation to our performance** in patient safety and we will recognise and highlight achievements in patient safety improvement.
- 5.6 We will **measure compliance with the National Standards for Safer, Better Healthcare** and report on implementation.
- 5.7 We will support **patient safety research** and publish and act on the results.
- 5.8 We will further **develop and enhance technology solutions**, including eHealth, to improve access to and reliability of information to measure and improve patient safety.

# 6

## **Commitment 6: Leadership and Governance to Improve Patient Safety**

We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance.

### **Rationale**

Effective leadership and governance, adequate supports for patient safety, appropriate infrastructure, skills, team-working, knowledge, values and behaviours are critical to patient safety. Leadership is fundamental to shaping an organisational culture with safe, person-centred and compassionate care at its core. Effective governance provides the necessary structures, processes, standards and oversight at every level of the organisation to ensure that services are safe.

### **Patient Safety Principle**

Leaders, managers and clinicians across health and social care services will be visible and active in influencing the safety of care by shaping culture and building resilience within the organisation, setting direction, providing support to the workforce, implementing a systems approach to safety improvement and monitoring progress and improvement in safety performance.

## Commitment 6: Leadership and Governance to Improve Patient Safety

### Actions

- 6.1** The **HSE Board will demonstrate its commitment to patient safety** by endorsing this Strategy and by monitoring its implementation.
- 6.2** Patient safety, including **safety performance and improvement** and **anticipating and managing** risk, will be a **priority** at all levels of the organisation.
- 6.3** We will put in place a **National Patient Safety Programme** to support the implementation of actions set out in this Strategy.
- 6.4** The National Patient Safety Programme will prepare an **overall implementation plan for the Strategy**, progress against which will be publicly reported.
- 6.5** **Patient Safety actions** to implement this Strategy will be included in the **HSE's National Service Plan** and in each service level Operational Plan.
- 6.6** We will **strengthen clinician leadership for patient safety at local and national level** to provide support and advice and to lead the integration of national efforts to improve patient safety.
- 6.7** An **investment strategy for patient safety** will be developed for approval by the HSE Board to address risk-prioritised patient safety issues both at national and service level.
- 6.8** We will support appropriate **governance arrangements for patient safety** (including appropriate clinical governance structures) in line with the requirements of Sláintecare<sup>7</sup>. There will be defined responsibilities for Boards, management, staff and relevant multidisciplinary quality and safety committees.
- 6.9** We will work with **staff and relevant training bodies to support the development of leadership** (including clinical leadership) for patient safety across health and social care services. This leadership will seek to adopt and embed in our health and social care services behaviours that promote teamwork, collective decision making and trust.
- 6.10** We will **align staff skilled in quality and patient safety** with patient safety initiatives to support the achievement of the objectives of this Strategy.
- 6.11** We will develop a **comprehensive communications programme and supporting awareness campaign** to engage support for patient safety amongst the public and health and social care staff and to disseminate learning and good practices.

7 Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, [https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee\\_on\\_the\\_future\\_of\\_healthcare/reports/2017/2017-05-30\\_slaintecare-report\\_en.pdf](https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf)

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8 This is not intended to be an exhaustive list. Additional background information and relevant national and international references are available on the HSE Patient Safety Strategy website.



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# Appendix 1: Patient Safety Strategy: Our Ambitions for Patient Safety

Having the safest health and social care possible requires that we do all we can to ensure that we have staff with the capacity and capabilities they need to practice and provide safe care, we recognise patients as partners in this process and acknowledge the need to learn from them, and we have systems that support staff to do their job safely and enable people to work together effectively.

## What the Patient Safety Strategy will mean for Patients:

### 1. I have what I need to feel safe and to take responsibility for my own safety:

- Full knowledge about my condition, treatment options and risks associated with my condition.
- Knowledge of what I need to do to treat my condition and remain well.
- Information provided to me in a way that I can understand.
- Knowledge of how I can obtain additional information and/or who I can contact.
- Knowledge of advocacy and patient support services and how to access same.
- Assurance in relation to the privacy, confidentiality and proper use of my personal data.

### 2. I have what I need to contribute to improvement in patient safety:

- Knowledge of who and how to contact to highlight patient safety issues.
- Supports and opportunities to participate in the design and implementation of patient safety improvements.
- Supports and opportunities to provide feedback on patient safety improvement initiatives.

### 3. I have what I need to partner with the health and social care services to inform and influence the future development of safe and person centred healthcare:

- Knowledge about safety partnerships with the health and social care services and how I may be involved.
- Access to appropriate training in patient safety and skills such as facilitation and advocacy.
- A commitment that my views and the views of the patients I represent will be heard and respected.

## What the Patient Safety Strategy will mean for Health and Social Care Staff:

### 1. I have what I need to do my job:

- Defined roles and responsibilities – including the reporting of adverse events.
- Access to appropriate training.
- Capacity and capability appropriate to needs.
- Appropriate equipment and environment.
- Access to high-quality patient safety data and information.
- Leadership, governance and management support.

## 2. I have what I need to work effectively with others for safety:

- An understanding of Team and Human Factors.
- Patient partnership skills.
- Communication, negotiation and conflict resolution skills.
- Ability to deliver care compassionately and reliably, to be sensitive to daily operations and to predict and respond to problems.

## 3. I have what I need to improve safety:

- An understanding of Patient Safety Science and reliability.
- An ability to respond to and learn from adverse events and to identify report and proactively manage risk.
- A culture of continuous improvement and knowledge and skills for improvement.
- Time and priority for improvement efforts and management support.

## 4. I have what I need to implement and sustain new safety practices:

- Evidence based and co-designed set of interventions.
- Information, educational materials and training.
- Measurement skills and tools.
- Local and national support and resources.

## What the Patient Safety Strategy will mean for the Health and Social Care System:

### We have systems that:

- Provide safer, better healthcare.
- Are evidenced based, supported by timely and meaningful data, appropriate Policies, Procedures and Guidelines and are designed to anticipate or prevent error or alert staff rapidly when an error has occurred.
- Enable the co-production of safe healthcare with patients.
- Enable staff to learn together and to learn from patients.
- Allow effective communication and dissemination of learning.
- Provide appropriate capability for patients and staff to enhance safe care.
- Support a culture of meaningful measurement and improvement for safety.

## Appendix 2: Patient Safety Strategy Co-design Group

A Co-design Group was established to develop the Patient Safety Strategy. The group had representation from patients and both corporate and service provision levels of the health service.

### Membership of Co-design Group:

- Mr. Patrick Lynch, National Director, Quality Assurance and Verification (QAV)
- Dr. Cate Hartigan, Lead, Patient Safety Programme (appointed May 2019)
- Dr. Sean Denyer, Public Health Lead, QAV (Chair of the Co-Design Group)
- Dr. Samantha Hughes, QAV (Project Lead, Patient Safety Strategy)
- Ms. Kara Madden, Patient Representative (Patients for Patient Safety Ireland, and on behalf of the National Patient Forum)
- Ms Iryna Pokhilo, Patient Representative (Cairde, and on behalf of the National Patient Forum)
- Ms. Cornelia Stuart, Assistant National Director, QAV
- Dr. John Fitzsimons, Clinical Lead, Quality Improvement Team (QI Team)
- Ms. Deirdre McNamara, General Manager, Office of the Chief Clinical Officer
- Ms. Ciara Kirke, Clinical Lead, Medication Safety Improvement Programme, QI Team (deputised by Ms. Muriel Pate, Medication Safety Improvement Programme, QI Team)
- Ms. Margaret Brennan, Assistant National Director, Quality and Patient Safety (QPS) Lead, Acute Operations
- Mr. JP Nolan, Assistant National Director, QPS Lead, National Community Healthcare
- Ms. Celia Cronin, QPS Lead, South Southwest Hospital Group
- Ms. Annette Logan, QPS Manager, Cork Kerry Community Healthcare
- Dr. Sarah Condell, National Patient Safety Office, Department of Health
- Ms. Rosarie Lynch, National Patient Safety Office, Department of Health
- Ms. Susan Reilly, National Patient Safety Office, Department of Health
- Ms. Deirdre Hyland, National Patient Safety Office, Department of Health

### Consultation Process

A comprehensive consultation process was undertaken to provide an opportunity for all stakeholders including HSE providers, staff and patients, to review and comment on the draft HSE Patient Safety Strategy and its implementation. Feedback from the consultation was used to inform the development of the final draft of the Patient Safety Strategy prior to its review and approval by the HSE Executive Management Team and HSE Board. The consultation process involved the following stakeholder groups:

- |   |   |
|---|---|
| 1. Dept. of Health, National Patient Safety Office (NPSO)   | 6. HSE QPS Leads and staff              |
| 2. HSE Corporate  | 7. Patients and Patient Representatives |
| 3. Service Level: Hospital Groups (CEOs and Clinical Leads) and Community Healthcare Organisations (Chief Officers) | 8. Provider Organisations               |
| 4. National QPS Office, Community Health Care   | 9. External Bodies                      |
| 5. National QPS Office, Acute Operations  | 10. All other HSE staff                 |

In addition, the draft Patient Safety Strategy was discussed and critically appraised on 28th February 2019 during a joint meeting of representatives from the HSE, National Patient Safety Office (Department of Health) and members of the Scottish Patient Safety Programme.





**Contact Details:**

Quality Assurance and Verification,  
Office of the Chief Clinical Officer,  
Health Service Executive,  
Dr. Steevens' Hospital,  
Steeven's Lane,  
Dublin 8, D08 W2A8

[www.hse.ie/eng/about/qavd/patient-safety/](http://www.hse.ie/eng/about/qavd/patient-safety/)

**Phone:** 01 6352619

**Email:** [national.qav@hse.ie](mailto:national.qav@hse.ie)

**Publication Date:** December 2019

**ISBN No:** 978-1-78602-127-4