Patient Safety Strategy 2019-2024

Pre-Consultation Draft

28th February 2019

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Contents

Foreword 1: HSE Chair/DG/CCO

Key points to be included in Foreword:

- Priority strategy for the HSE
- Our priority for the next 5 years: A culture where safety is seen as a priority, where all patients attending our health services will consistently receive the safest health and social care possible.
- Partnership with patients and service users
- Board Commitment to the strategy
- Commitment to implementing meaningful patient safety improvement initiatives in partnership with patients and staff
- Strategy developed in conjunction with the NPSO in DoH and NPSO will continue to interface with the HSE in the implementation of the strategy
- The strategy adopts six commitments for patient safety and describes strategic actions for implementation of these principles and commitments i.e.
  - Empowering and Engaging Patients to Improve Patient Safety
  - Empowering Staff to Improve Patient Safety
  - Anticipating and Responding to risks to Patient Safety
  - Reducing Common Causes of Harm
  - Using Information to Improve Safety
  - Leadership and Governance to Improve Safety
- A number of prioritised patient safety challenges have been identified for initial focus such as…
- We will develop implementation plans and prioritise initiatives to address these in the first instance while constantly reviewing patent safety concerns in order to prioritise other patient safety and improvement initiatives in response to specific patient safety needs
- National Patient Safety Programme led by the CCO in place to ensure the actions set out in this strategy are progressed and to assist in integrating patient safety activities across the health service.
- Implementation Plan will be developed and will be monitored

Foreword 2: Patient Representative

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Introduction

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 excellent care, placing our trust in professionals to improve our health or provide a service that will support us in living fulfilled lives.

When we use health and social care services we expect to be kept safe. Maintaining the highest levels of patient safety is a fundamental priority for patients and for healthcare organisations. It is estimated that up to 17% of all hospitalisations are affected by one or more adverse events, with 30-70% potentially preventable[1]. Studies from Australia, Canada, the United States and European countries suggest that between 2% and 16% of deaths may be attributable to adverse events[2]. The Irish National Adverse Event study, identified that the overall adverse event prevalence (i.e. the proportion of admissions associated with one or more adverse events) in an Irish hospital was 12.2%. They found that adverse events were estimated to cost Irish hospitals more than €194 million a year, about 4% of the health care acute services' budget[2].

The HSE's National Service Plan 2019 commits to implementation of a national patient safety strategy. It also commits to putting in place new governance arrangements to support and oversee implementation of the strategy and the further development of targeted patient safety initiatives.

The *Patient Safety Strategy 2019-2024* builds on the progress made in reducing patient and service user harm in recent years and seeks to place patients and service users at the heart of improving safety. Key to sustained improvement in patient safety is nurturing a culture of patient safety which places emphasis on transparency and learning. This is supported by true engagement with patients and staff, effective governance and leadership, and transparency and openness to enhance patient safety capability. This culture is also underpinned by effective measurement and monitoring of safety, coupled with improvement methods that continuously address the quality, safety and experience of care.

While it is recognised that improving safety is just one element of the multifaceted quality improvement agenda, improving the safety of our healthcare services and reducing patient harm has been identified as a priority focus for the HSE, and that improvements to patient safety will have a hugely positive impact on the quality of the healthcare services we provide to patients.

This strategy sets out the HSE's vision for patient safety as well as the underlying principles, commitments and actions that will be undertaken at each level of the health service to progress the implementation of the strategy, in order to improve patient safety and the quality of the healthcare service we provide to patients.

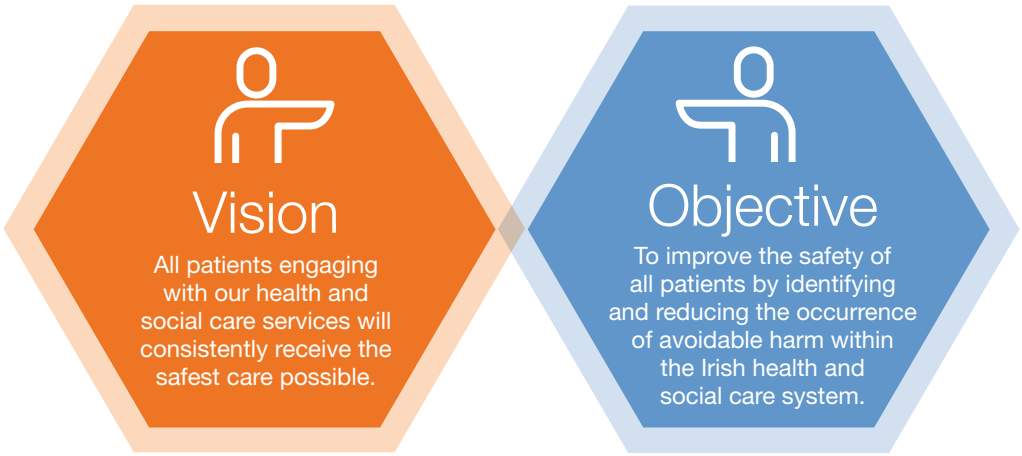
The HSE Framework for Improving Quality (2016) provides a strategic approach to improving quality at every level of the health service. The principles and processes described in the Framework are central to identifying, implementing and sustaining the required improvements to patient safety.

A National Patient Safety Programme has been established within the Office of the Chief Clinical Officer (CCO) in order to oversee and monitor the implementation of this strategy. An immediate priority of the organisation will be the development of an implementation plan and implementation will involve a partnership with patients, staff and other bodies such as the Department of Health, HIQA, MHC, State Claims Agency and the Professional Bodies.

Patient safety must be everyone's business. Throughout the strategy it is intended that the term "we will" will infer that actions will be developed and implemented at every level of the organisation, both at corporate and service level as appropriate, in order to improve patient safety.

Note: *In this strategy the term 'patient' is intended to include all people who use health and social care services. The term "clinician" is used to indicate all healthcare professionals.*

Patient Safety Strategy:
Our Vision & Objective for Patient Safety



Patient Safety Strategy:
Our Ambitions for Patient Safety

Ensuring we have the safest 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, that we recognise patients as partners in this process and acknowledge the need to learn from them and equip them with information and appropriate skills.

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, risks associated with my condition and 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

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 training 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 error and harm
- Access to appropriate training
- Staff capacity and capability appropriate to needs
- Appropriate equipment and environment
- 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 and Patient partnership skills
- Communication, negotiation and conflict resolution skills
- Ability to deliver care reliably, to be sensitive to daily operations, 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, knowledge and skills for quality improvement, time and priority for improvement efforts and management support

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

- An evidence based, 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

1. We have systems that that support staff to do their job and enable people to work together effectively:

- Systems which enable staff to learn together and from patients
- Systems that allow effective communication and dissemination of learning
- Systems that provide needs based training for patients and staff to enhance safe care
- Systems that are evidenced based, supported by appropriate Policies, Procedures and Guidelines and are designed to anticipate or prevent error or alert staff rapidly when an error has occurred

Patient Safety Strategy:
Our Commitments to Patient Safety

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

Patient Safety Commitments

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 patients to design, deliver, evaluate and improve care.

2

Empowering and Engaging Staff to Improve Patient Safety

We will work to embed a culture of fairness, openness, learning and improvement. We will support staff to keep patients safe in their practice, including identifying and reporting safety deficits, managing and improving patient safety.

3

Anticipating and Responding to risks to Patient Safety

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

4

Reducing Common Causes of Harm

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

5

Using Information to Improve Safety

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

6

Leadership and Governance to Improve Safety

We will embed a culture of patient safety improvement at every level of the health 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 patients to design, deliver, evaluate and improve care.

Rationale

Key to patient safety and patient-centred care is a culture where patients, carers, advocates and health care professionals work together in partnership in order 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 own care and in the process of designing, delivering and improving care.

Patient Safety Principle

Patients, carers, families and advocates, in the knowledge that their views will be heard and respected, will know what patient safety means, how it emerges and will have an active role is in making our services safer.

Actions

1.1	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.
1.2	We will implement initiatives, including the Patient Information Project, in order that patients will have the required information, knowledge and skills about their condition, complex care needs and treatment options so that they may be empowered to support their own safety..
1.3	We will participate in the **National Care Experience Programme** and **National Patient Experience Surveys** in order to enhance the ability of the health service to **listen to and act on the voice of patients**.
1.4	We will develop **resources and supports** with patients that draw on their experiences and expert knowledge.
1.5	We will identify and address the **training and information needs** of patients, carers, families, patient representatives and advocates in order to enable them to contribute fully to improvements in patient safety including reporting incidents and patient safety issues.
1.6	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.
1.7	We will develop a **national function reporting to the Chief Clinical Officer** with a particular responsibility for enhancing our approach to meaningful partnerships with patients.
1.8	We will continue to **implement relevant legislative provisions** and policies in relation to Patient Safety and Open Disclosure in order to further embed a culture where we acknowledge when things go wrong, offer meaningful apologies, and act to put things right.
1.9	We will **support patients and families following an adverse event** through open communication and engagement, understanding what went wrong and identification of measures to reduce the risk of recurrence.

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

We will work to embed a culture of fairness, openness, learning and improvement. We will support staff to keep patients safe in their practice, including identifying and reporting safety deficits, managing and improving patient safety.

Rationale

Creating and maintaining a positive safety culture is central to the mission of our health and social care services. It is a culture where safety is seen as a 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, involved in decisions which affect the safe delivery of care and provided with the skills, support and time to engage in safety improvement initiatives.

Patient Safety Principle

Health and social care service leaders and 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 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.

Actions

2.1	Systems and processes will be implemented in order to **ensure that staff are effectively listened to**, communicated with, fully involved and engaged in the planning and delivery of the services they provide and supported and facilitated to raise safety concerns and improve patient safety.
2.2	We will **enhance the capacity and capability of staff** to improve patient safety by designing and delivering safety information and training to include patient safety and reliability science, audit, quality improvement, human factors and team working for safety.
2.3	In **partnership with professionals and training bodies**, we will develop strategies to promote behaviours that support a culture of safety including communication and multidisciplinary team working.
2.4	We will facilitate the continued development of coordination, networking, sharing and learning for patient safety amongst patient safety leaders, clinicians and external agencies such as HIQA, Mental Commission, Health and Safety Authority and State Claims Agency.
2.5	We will continue to support staff in **reporting and learning from incidents**.
2.6	We will improve and develop **supports and care for staff** affected by their involvement in serious patient safety incidents.
2.7	We will **measure the culture of patient safety** and identify and implement actions to address identified deficits.
2.8	We will continue to **support programmes promoting patient safety culture and person-centredness**, including the HSE's Values in Action programme, the National Healthcare Communication Programme and the Culture of Person-Centredness Programme.
2.9	Using risk-based prioritisation, we will facilitate and coordinate efforts to assess, plan and manage **workforce requirements for implementing improved patient safety practices**.

3 Commitment 3: Anticipating and Responding to risks to Patient Safety

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

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 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-based one.

Patient Safety Principle

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

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 to ensure 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-based one.
3.5	We will put in place systems for analysing patient safety data and intelligence to allow us assess risks to patient and service user 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 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 organisations accountability arrangements.
3.8	We will integrate patient safety information and data to allow us to analyse the reliability of healthcare processes, proactively identify areas of risk to patient safety and inform safety improvement programmes.
3.9	We will publish data in relation to patient safety across the health and social care service.
3.10	We will implement National Clinical Guidelines produced by the National Clinical Effectiveness Committee.
3.11	We will strengthen clinical and healthcare audit governance and processes to provide assurance in relation to the safety of 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 high impact patient safety risks which, if tackled effectively, can have result in improving safety in healthcare organisations(3-8). Many initiatives, programmes, collaboratives etc. are already working towards addressing these challenges across the health and social care services. Prioritised patient safety initiatives will consider all patients and service users whether they have physical and/or mental healthcare needs.

Patient Safety Principle

The implementation of best practices for patient safety and quality improvement initiatives to achieve a measurable reduction in patient harm in prioritised safety areas.

Internationally recognised Patient Safety Initiatives prioritised for action

Reduction of Healthcare Associated Infection and Antimicrobial Resistance	**Reducing Medication Related Harm**	Recognising, Reducing and Managing Venous Thromboembolism (VTE)	**Prevention and Management of Pressure Ulcers**
Reducing and Managing Sepsis	**Recognition and Management of the clinically deteriorating Patient**	**Reducing Risk of Harm from Falls**	Safeguarding Vulnerable Patients
Improving Safety at Transitions of Care including clinical handover	**Prevention of Violence, Harassment and Aggression**	**Enhanced safety for Mentally unwell service users**	Ensuring safe procedures of care within high risk environments

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.
4.3	Through the National Patient Safety Programme [recommendation 6.2] we will monitor the implementation plan and the attainment of patient safety improvements.
4.4	We will constantly monitor and review patent 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 the health service.
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 Safety

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

Rationale

The measurement of patient safety is complex. In order to make healthcare safer, organisations must be transparent and open, continually measuring harm and reliability, 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.

Actions

5.1	We will further develop and enhance local and national suite 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** and evaluate the effects of safety improvement initiatives.
5.3	We will develop **patient safety surveillance systems** using a range information sources including incident and risk data, quality and safety metrics, assessments against national standards, patient engagement, staff engagement, claims, complaints, incident reviews, clinical audit, regulatory reports, Coroner's reports, mortality reviews and research.
5.4	We will publish an **annual report** in relation to our performance in relation to patient safety.
5.5	The HSE will roll out the **Quality Assurance and Improvement tool** to measure compliance with the National Standards for Safer, Better Healthcare and produce an annual report on implementation.
5.6	We will support **patient safety research** and publish and act on the results.
5.7	We will further develop and enhance **technology solutions**, including eHealth, to improve access to and reliability of information in order to measure and improve patient safety.

6 Commitment 6: Leadership and Governance to Improve Safety

We will embed a culture of patient safety improvement at every level of the health 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, patient-centred 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 for patients.

Patient Safety Principle

Leaders, managers and clinicians across the health and social care service will be visible and active in influencing the safety and quality of care by shaping culture within the organisation, setting direction, providing support to the workforce, and monitoring progress and improvement in safety and quality performance.

Actions

6.1	The **HSE Board** will demonstrate its commitment to patient safety by endorsing this Strategy and by monitoring and reporting on its implementation. Quality, patient safety and risk, including safety performance and improvement, will be a priority at all levels of the organisation.
6.2	We will put in place a **National Patient Safety Programme** led by the CCO to ensure the actions set out in this strategy are progressed and to assist in integrating patient safety activities across health and social care services.
6.3	The National Patient Safety Programme will prepare an overall **implementation plan** for the strategy, progress against which will be detailed in an annual report.
6.4	Patient Safety actions to implement this strategy will be included annually in the **HSE's National Service Plan** and in each service level Operational Plan.
6.5	We will appoint a **National Clinical Lead for Patient Safety** as part of the National Patient Safety Programme who will govern and consolidate national efforts to improve patient safety.
6.6	An **investment strategy** for patient safety will be developed for approval by the HSE Board in order to address risk-prioritised patient safety issues both at national and service level.
6.7	We will ensure appropriate **governance arrangements for patient safety** are in place at every level of the health service. There will be defined responsibilities for Boards, management, staff and relevant interdisciplinary quality and safety committees.
6.8	We will work with **senior clinicians and clinical training bodies** to support the development of clinical leadership for patient safety across the health service.
6.9	We will **assess and align staff skilled in quality and patient safety** with patient safety initiatives, in order to support the achievement of the objectives of this strategy.
6.10	We will develop a comprehensive **communications programme** and supporting awareness campaign to engage support for patient safety amongst the public and health service staff and to disseminate learning and good practices.

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Appendix 1:
Patient Safety Strategy Co-design Group

A Co-design Group, led by a project lead developed the draft strategy document. 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, QAVD
- Dr. Sean Denyer, Public Health Lead QAV [Chair of the Co-Design Group]
- Dr. Samantha Hughes, QRS, QAVD [Project Manager, Patient Safety Strategy]
- Ms. Kara Madden, Patient Representative
- Ms Iryna Pokhilo, Patient Representative
- Ms. Cornelia Stuart, Assistant National Director, QAVD
- Dr. John Fitzsimons, Clinical Lead, QID
- Ms. Deirdre McNamara, General Manager, Office of the Chief Clinical Officer
- Ms. Ciara Kirke, Clinical Lead, Medication Safety Improvement Programme, QID (deputised by Ms. Muriel Pate, Medication Safety Improvement Programme, QID)
- Ms. Margaret Brennan, QPS Lead, National Acute Hospitals
- Mr. JP Nolan, 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, Dept. of Health
- Ms. Rosarie Lynch, National Patient Safety Office, Dept. of Health
- Ms. Susan Reilly, National Patient Safety Office, Dept. of Health
- Ms. Deirdre Hyland, National Patient Safety Office, Dept. 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 Leadership Team and HSE Board. The consultation process involved the following stakeholder groups:

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

CONTACT DETAILS TO BE INSERTED

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