



Seminar

Patient Safety in the Community

20 January 2026

University of Limerick, Limerick

Proceedings

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The **Safety Themes Group** at the University of Limerick conducts research and consultancy in aviation safety, airworthiness and patient safety.

In Safety Themes, we discuss, analyse and critically evaluate topics of importance for the safe practice of aerospace and healthcare professionals.

Driven by curiosity, we intend to identify what and how can be improved through an independent lens and an evidence-informed approach.

The Group is also engaged in education offerings in the same fields.

More details on our work can be found at: <https://www.ul.ie/research/safety-themes>



School of Nursing and Midwifery

Associate Professor Liz Kingston, Head of School Nursing and Midwifery, Faculty of Education and Health Sciences, University of Limerick

As Head of the School of Nursing and Midwifery at the University of Limerick, I am immensely proud of the School's evolution since its foundation in 2003, and of its central role within a modern, research-active university established in 1972 and designated as University of Limerick (UL) in 1989. Situated in the Health Sciences Building on UL's North Bank Campus, the School is a vibrant academic community committed to preparing nurses and midwives who are clinically skilled, research-informed, and globally engaged. Our mission (to engage in dynamic and transformational teaching and research that significantly improves the health and wellbeing of local, national, and global communities) guides every aspect of our work. Research is a core pillar of the School: our staff and students undertake studies that shape healthcare policy, enhance patient outcomes, and advance scholarship across general, mental health and intellectual disability nursing, and midwifery practice.

Organising seminars such as *Patient Safety in the Community* is essential to our mission and to the culture of collaboration we seek to nurture. Events like this allow us to bring together clinicians, researchers, policymakers, patient advocates, and community partners to critically examine the challenges facing contemporary healthcare, particularly in areas such as communication, medication safety, continuity of care, and system integration, all of which emerged strongly in this seminar's discussions. By convening diverse stakeholders under one roof, the School strengthens the bridge between research and practice, supports the translation of evidence into real-world improvements, and fosters an environment where shared learning drives safer, more person-centred care. As a School committed to advancing patient safety and empowering healthcare professionals, hosting events of this kind is a vital part of our contribution to national and international healthcare improvement.

Acknowledgements

I would like to express my sincere appreciation to all presenters for their insightful and engaging contributions. My special thanks also go to Dr. Jill Poots, Network Manager of EQUIPS and Research Fellow at Trinity College Dublin, for her collaboration and support in organising this event.

I would also like to extend my gratitude to Sinéad Walsh, Research Assistant with EQUIPS; Dr. Yeojin Kil (University of Limerick); Dr. Gemma Moore (HSE); and Chris Cavanagh (HSE) for their continued dedication and support in ensuring the successful delivery of this seminar.

We gratefully acknowledge the Health Research Board (HRB) for funding this seminar and for their ongoing collaboration throughout the project.

Disclaimer

The transcripts included in this report were exported directly from Microsoft Teams and may therefore contain inaccuracies or transcription errors. Only minor, non-substantive edits have been made to improve clarity and readability. The report also contains copies of all presentation slides as provided.

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Welcome speech

Professor Deirdre McGrath, Executive Dean, Faculty of Education and Health Sciences, University of Limerick

So good morning, everybody and to everybody online. So, my name is Deirdre McGrath. I'm the Executive Dean of the Faculty of Education and Health Sciences. And maybe just to give you by way of background, to give you an understanding of my background, I'm a hospital based clinician, not community healthcare. Obviously, but through my role previously to this is head of the School of Medicine and also uh, more recently my role as Executive Dean of the Faculty of Education and Health Sciences. I've had a significant amount of engagement with our community partners here in the Midwest, so I'm well aware of the incredible work that our partners do and also of.

Some of the complexities and challenges that they face. So, I really, I think this is hugely important conference today. So I really do hope that you get the most out of the day and that you have the opportunity to contribute and to also meet some people maybe that you don't know already or that you didn't know already and that might be useful.

In, uh, the work that you do in the community and here in the university settings. So good morning, everybody and welcome. It's my great pleasure to open today's seminar here at the University of Limerick and on behalf of the Faculty of Education and Health Sciences, I extend a warm welcome to all our distinguished guests, colleagues, partners and.

Participants who've joined us for this very important event, and I know there's a number of individuals online as well. So, today's seminar focuses on a topic that is both timely and critical patient safety in community healthcare. Over the past decades, healthcare systems worldwide have made significant strides in improving. Safety within acute settings. However, as evidence increasingly shows, adverse events and safety challenges are not confined to hospitals. They occur in community settings too. So, these environments, with their unique complexities and resource constraints, require our urgent attention.

So this seminar is designed to create a national platform for dialogue, collaboration and knowledge exchange. The aim is to get is to bring together voices from across the spectrum, patients, healthcare providers, policymakers.

Academics and advocates to share insights, experiences and innovative practices that

can shape safer care in our communities. By doing so, we hope to inform future research, policy and practice, ensuring that patient safety becomes a cornerstone of community health.

So I would like to acknowledge the Health Research Board for supporting this initiative and the Evidence Based Quality Improvement and Patient Safety Research Network for their collaboration. Their commitment to advancing patient safety research in Ireland is invaluable.

So a sincere thank you to all our speakers and contributors who will share their expertise and perspectives throughout the day. Your insights will help us better understand the challenges and opportunities for improving safety in community healthcare. I would also like to thank Anna Chatzi and the organizing team and everybody who worked.

Behind the scenes to make this event possible, even the person who turned on the heating this morning.

So while, unfortunately, due to all the commitments I have to leave after this welcome address, I am hugely confident that the scheduled planned by our UL team will encourage significant discussion and knowledge sharing, and I would encourage each of you to ask questions.

Share your experiences and connect with others in the room or online. This should not just be a seminar, but the start of a new collaboration and practical actions that will make a real difference in community healthcare. Together, you can turn ideas into impact.

In the words of Nelson Mandela, education is the most powerful weapon which you can use to change the world. So please use today as an opportunity to learn, to challenge and to lead change for safer care in our communities. Thank you and wishing you a very productive and a really inspiring day.

Speech 1

Actions to prevent medication related harm in the community by highlighting a number of key resources for high risk medications and situations

Louisa Power, Registered Pharmacist, Medication Safety Specialist Pharmacist, Health Service Executive (HSE)

Good morning, everybody, and thank you to Anna and the whole team, I suppose, for putting together this wonderful agenda. And I suppose it's my honour and my pleasure today to be part of this.

This wonderful event and what I really want to talk about today is around preventing and harm and very much focusing on medication safety in the community. So, I'm a medication safety specialist pharmacist and I work with the National Medication Safety Programme and we're part of the National Quality and Patient Safety Directorate within the HSE.

So, I just want to give you a quick overview as to what I'm going to cover in this slot. So, I'm going to give you an overview of what who we are in the National Medication Safety Programme. I'm going to bring you through some key medication and safety data and I'm going to, I suppose, cover some resources that we have within the National Medication.

Safety program. So the no check, ask and the my medicines list and HSP medicines A to D and then finally looking at lithium safety and you'll see this infograph here on the left hand side and it comes from the WHO and it's that everyone has a role to play in medication safety.

And I suppose within the National Medication Safety Program, we're passionate about this. You know, it's not just the clinicians or the prescribers or the pharmacists who dispense the medicines or the nurses who administer the medication, but it's also the patients as well. And patient empowerment is absolutely key in relation to promoting medications.

Safety because the more information that our patients have and our service users have, the safer they can use medication and that's what a lot of our resources that we that we have focus on.

So, what is the National Medication Safety Program? So those of you who haven't heard of the National Medication Safety Program, as I said, we're part of the National Quality and Patient Safety team and we work with patients and healthcare providers to reduce patient harm associated with medicines are their omission and we provide

a systematic approach to medication safety across the system. So we don't. Just focus on acute. We also have a very keen focus on community and on social care and across the divisions as well into health and well-being, mental health, older persons and primary care as well. We have a dedicated page on the HSE website which is HSE forward slash safer meds and we also have a dedicated e-mail.

Inbox and we do receive, you know, quite a, you know, a busy traffic through that inbox in relation to queries around medication safety and also in relation to our resources as well. And that's just a little screenshot from our website.

So I was just to set the scene in relation to medication safety because often I get asked like why do we have, you know, a medication safety programme? Um. So I just want to focus on some kind of recent medication safety data just to show I suppose um the breadth of the issue. So, from the WHO, uh, patient harm due to unsafe medication care is the leading cause of death and disability worldwide. And what the WHO say is that most of this patient harm and it is avoidable and there is something that we can do about it.

And almost 50% of this preventable medication harm is related to medications and therapeutic interventions. And one in 20 patients or service users will experience preventable medication related harm in medical care. So you know when you think about a ward or a unit in residential care with 20 patients, one of those.

Will experience preventable medication related harm and a quarter of this harm is considered to be severe or life threatening and globally the cost associated with medication errors has been estimated 42 billion U.S. dollars annually and the WHO have identified 3 priority action areas which we also focus on in the National Medication Safety.

Program. They're polypharmacy, high risk medications and situations and at transitions of care.

And what the WHO have identified as medication is the most common cause of avoidable harm in healthcare. And as you can see the here on the left hand side or here on the right hand side, you've got three reports that WHO have published.

In relation to these three priority action areas, so they they've looked at polypharmacy, high risk medications and situations on transitions of care and they look at you know across the system. So they look at you know actions that can impact patients in the public, healthcare professionals, medicines and systems and practices of medication and this is how.

We, I suppose in the National Medication Safety Program, look at our particular tasks and our particular actions and looking across not just healthcare professionals, but also looking at the system and the practices of medication and also looking very much and focusing on patients and the public and looking at things around.

Patient engagements and involvement of patient organisations as well, because we work quite closely with patients for Patient Safety Ireland and this is data that was

actually recently issued by the States Claims Agency in Ireland, so in December 2025. And they looked this is data from 2023 and 2024 and this is from NIMS data, so the National Incident Management System. So mainly HSE facilities, but not just in hospitals. It also looks at community facilities as well, but what it is HSE facilities. Doesn't cover, I suppose some of those community settings like community pharmacy or GP practices, but it does cover those HSE facilities. So you can see the profession of the reporter is our nurse, our nurses and our midwives, you know, report the widest or the largest portion.

Medication incidence followed by allied health care professionals, which is mostly pharmacists and pharmacy technicians and then down to general support. And unfortunately, not a lot of medication incidences are reported by medical staff. I suppose most of the medication incidences that we see are happening at the admin. Administration stage Um or at the prescribing stage. So you know those are areas that we do need Um to focus on Um in relation to medication safety. And this I suppose breaks down the medications that are um particularly I suppose Um reported. So we're looking at things like.

And.

You know, anti-thrombotic agents and blood thinning agents. So things like enoxaparin. We're also looking at paracetamol, and I often get asked why does paracetamol feature so widely because people wouldn't think that that's a particularly high risk medication, not like things like blood thinners and insulin, but I suppose most of most.

Our patients, most of our services, most of our residents are actually prescribed paracetamol and we see a lot of medication related incidences in paediatrics around paracetamol because often the dose of paracetamol is weight based and there are often errors there around prescribing and also in relation to administration.

We're seeing a large number of incidents relating to valproate, but that may be due to the foetal valproate syndrome and an inquiry that's ongoing in relation to women who were exposed to valproate during pregnancy and the outcomes from their children. We also see opioids as well, so.

Oxycodone and morphine sulphate and we see antibiotics and antimicrobials. And so we're looking at things like Vancomycin and insulin features quite highly there as well in the top 10. So suppose that just gives you a flavour of where the medication incidences are happening, who's reporting those meds.

Medication incidences and what medicines are implicated in those reported medication incidences. But that is really only the tip of the iceberg, because we can only go on what is actually being reported and we do know that you know it is actually a very small proportion of medication incidences that are reported.

So what can we do, I suppose, to try and make medication systems and processes safer. So, I'm going to focus on three key areas that we have within that that we

promote within the National Medication Safety Programme. So first I'm going to look at No Check Ask and the HSE My Medicines list.

So the no check ask, this actually comes from the WHO and it's their medication safety campaign and that was developed to support their third global patient safety challenge, which is medication without harm. And the aim of the campaign is to encourage those taking medication and their caregivers to take a more active role in managing their medication to help increase awareness and educate the public.

About the importance of and using and importance of using medication safety. So this is very much a patient empowerment and a patient engagement campaign. But it also encourages healthcare professionals to know the medicines that they're using, to check the details and to ask the patient if they understand. And what we really want to do is we want to support people to be more involved in decisions about their medication.

And to encourage them to report issues and concerns about their medication and to keep an up-to-date my medicines list.

So with the My Medicines list, this was developed by the by the HSE National Medication Safety Programme to support the No Check Ask campaign. And so everyone who takes regular medicines is encouraged to keep an up-to-date list for their medication. And it's a self, it's a self-management, but it's also a communication tool as well and what we and.

And those who have the My Medicines list are encouraged to share it with anyone that's involved with their healthcare and to also share it with staff at healthcare appointments. And for healthcare professionals, what we want, uh, what we encourage you to do is to make it easy to use and to make it available, ask the patient for it and very importantly give it back to them and you can see here that. The front of it is the My Medicines list and instructions on how to use it. And there's also space for the person to record their pharmacy name, the pharmacy telephone number, family doctor name and their emergency contact. And then on the inside there is space for them to record the information in relation to their medicines and how they.

At how they take those medicines, and I suppose we're also involved with the development of the HSE app. So on the HSE app there is a dedicated area for people to keep an up to date my medicines list. They can actually pull data from what's. Dispensed data from the HSE and we've been very heavily involved in the development of that particular module in the in the HSE app and it very much mirrors the My Medicines list. But for those people who cannot or will not use the app, we are still promoting.

the um the paper version. As I said, we have a dedicated website on the HSE or dedicated page on the HSE website which has resources for our lists, our posters and our videos. Our list has actually been translated into 52 languages. And if you want

to order copies of the blank list in English, you can go to www.hs.org.

W dot health promotion dot. If you sign up for an account which is free of charge and search for medicines, you can order a very large quantity of those medicines. If you want to download or to access the list that's been translated into 52 languages, if you want to our website, you can download and print that off and we also have a promotional video as well on.

Why and how to use the list and we can share the MP MP3 recording of that promotional video. And we do know that in some hospitals and healthcare facilities that have screens, they actually do show the promotional video. If anyone's if anyone wants some of the blank medicines lists are in are in the room today. I have. I have some supplies with me as well.

This is I suppose a link to the video. We also have a QR code as well. So if you want to access the video and access our resources, you can scan the QR code and our and our video is available on YouTube.

So as I said, this is what the My Medicines list looks like. You've got the section on the front to record the important information and then the and then and then on the back around recording the name of the medicine, the strength, how much they take, how I take it, do I take it every day, why I take it and my notes.

And I suppose these are just some tips around how to use my medicines list. Some people find it useful to keep a photo of the list or to take a photo with the labels in full view. And then it can be helpful to share this list with a family member or carer and to bring it with you when you're attending any healthcare appointment. And I suppose there's an assumption out there and most patients that because we're often all at screens that we that.

You know they we should have this information, but it's important to explain to patients and to their carers that the healthcare team do not have that information and also to remind them to keep the My Medicines list up to date. And I suppose we have done quite a lot of work in relation to promoting and the My Medicines.

So this is just some social media from campaigns in relation to how we've promoted the My Medicines list in the community and also in the acute setting as well. And here are some suggested actions around, you know, enclosing the My Medicines list with appointment lectures. We know some hospitals are doing that, that there are posters and videos being displayed in waiting rooms in public areas and.

Some residential settings as well that residents are being facilitated to compile and maintain their medicines list and also to promote the My Medicines list and the no check ask at public events and at staff events as well. And I suppose this is just some you know some of the questions that we do get asked you know is it reliable and who fills it in. So it's very much around the patient.

Filling.

In and because there's significant benefits to the person filling it in but you know a

list from the pharmacy can also be an alternative or an or an aid as well. But we are aware that healthcare professionals can support in some in some residential settings as well and this is some research that I suppose supports the use of the no check ask and the my medicines list.

And looks at the at the reliability, the time and the facilitators and the main facilitator really is a promotional list by healthcare staff and the access to digital and compact list which we're working with HSE digital in relation to the app and we have some on some acts, some online learning as well which is available on HSE land and also. IIOOP platform and that's for, you know, registered pharmacists very quickly, just looking at the medicines A to Z. So, this is the top 50 currently, but we will have the top 100 hopefully by the end of March. Most commonly prescribed medicines in alphabetical order. There's links to information on accessing patient information leaflets if the medicine is last listed.

We.

Very. We very high traffic on the medicines A to Z. So, we have nearly 700,000 page views last year and in 2024 and people do spend a significant amount of time. It's not just clicking on and clicking off, we do actually read the content. So, with NHS content we adapted for Ireland. There's a process of clean English checks and there's also clinical checks.

By a pharmacist, by the National Medication Safety Program, by a GP. And as I said, there's more development coming shortly. Very quickly, I just wanted to identify the lithium safety. So why I suppose did we focus on lithium therapy? So, patients with previous very stable lithium levels have been.

6.

Develop severe lithium toxicity after starting on medicines that interact with lithium, such as anti-inflammatories and diuretics, and this is particularly maybe medicine like anti-inflammatories such as ibuprofen that people are buying over the counter.

There's also been incidences where signs and symptoms of lithium toxicity were not identified and dealt with urgently and.

Equivalent doses were not taken into account when switching from liquid to tablet formulations. There are some great key recommendations from the Irish Medication Safety Network best practice guidelines for prescribing and monitoring lithium therapy. So, they look at, you know, the monitoring at appropriate intervals, the management of lithium toxicity, patient care information.

Local policies and procedures and arrangements for monitoring and communication of blood results, as well as prescribing being explicitly agreed. So, the lithium patient information booklet is actually in its third version. Um, so it was it's a collaboration between ourselves and the National Medication Safety Program, the Saint John of God's Hospital Pharmacy Department and the Irish Pharmacy Union to.

Promote and support lithium therapy and empower patients to engage with their

healthcare professionals to discuss all aspects of lithium therapy monitoring and side effects. It has been successfully awarded the clean English mark by NALA and it's also been reviewed by the Medication Safety Network, the College of Psychiatrists and the ICGP, and it's got two parts. So, it's got a patient information section which looks at, you know, key aspects and.

Questions around what is lithium, signs and symptoms of lithium toxicity and things around you know that the patients will ask around alcohol and lithium and pregnancy and lithium. That is the link and we also have the QR code which will bring you directly to the PDF version. As I said, we're on version three which was updated in September 2025 if you want to.

Order copies. You can use the smart survey link. I also have some hard copies with me today if anyone wants, um, some hard copies. The key changes really is that we've updated the indications to include the treatment of aggressive or self-harming behaviour. There's some expanded information on using the liquid formulation. And missed doses and also some additional detail on using lithium in pregnancy. We also have a lithium Uh links to Uh template for a lithium checklist and tracker on our website as well and those documents can be downloaded and adapted Um for local use and really they are and its they were developed by a team in Dublin, North City and West to complement the lithium therapy patient information booklet and they are the links to the lithium check therapy checklist and tracker on our website. So some take home messages, unsafe medication practices and medication errors are a leading cause of injury and avoidable patient care in health care systems across the world. But there is something that we can do about them. You can support medication safety through practicing your own safe processes and through supporting patient empowerment and involvement. No Check Ask supports patient involvement in decisions about their medication, encourages the reporting of issues and concerns about their medication.

And also to keep me up to date my medicines list, lithium is a potentially toxic medicine with a narrow therapeutic index and recognise adverse effects on both renal and thyroid function. We have a wide range of resources available on our website to support lithium prescribing, monitoring and patient education and please signpost patients and colleagues to reputable medicines.

Management sources. So, then my medicines list and the no check ask is available on our website and the HSE Medicines ATC is available on the HSE website. Thank you very much.

**KNOW
CHECK
ASK**

Preventing Harm: Medication Safety in the Community

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1

Overview

- ▶ National Medication Safety Programme
- ▶ Key Medication Safety Data
- ▶ Know, Check, Ask and HSE 'My Medicines List'
- ▶ HSE Medicines A-Z
- ▶ Lithium Safety

EVERYONE
has a role to play
in medication safety

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2

National Medication Safety Programme

- Working with patients and healthcare providers to reduce patient harm associated with medicines or their omission
- Website – www.hse.ie/safermeds
- Email – safermeds@hse.ie

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3

Medication Safety Data

National Quality and Patient Safety | nqps@hse.ie | @NationalQPS

4

Key Data on Medication Related Harm

- Patient harm due to unsafe medical care is a leading cause of death and disability worldwide, and most patient harm is **avoidable**
- Almost 50% of preventable patient harm is related to medications and therapeutic interventions
- One in 20 patients experience preventable medication-related harm in medical care
- 1/4 of preventable medication related harm is considered severe or life-threatening
- Globally, the cost associated with medication errors has been estimated at \$42 billion USD annually
- Harm more likely with **polypharmacy, high-risk medicines/situations** and at **transitions of care**
- Panagioti M, et al. Prevalence, severity, and nature of preventable patient harm across medical care settings: Systematic review and meta-analysis. *BMJ*. 2019
- Robinson et al. Preventable medication harm across health care settings: a systematic review and meta-analysis. *BMJ* (med). 2020
- WHO report: Global burden of preventable medication-related harm in health care – A systematic review 2022

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5

Medication Without Harm: WHO Global Patient Safety Challenge

Medication is the most common cause of avoidable harm in healthcare

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State Claims Agency – December 2025

Medication Incidents by Stage of Process 2023/24

Stage	Percentage
Administration	53.7
Preparation/Dispensing	32.5
Supply/Ordering/Transport	5.3
Monitoring	3.4
Reconciliation	2.8
Other	2.2
Prescribing	0.1

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State Claims Agency – December 2025

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Know, Check, Ask
HSE 'My Medicines List'

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Know, Check, Ask

World Health Organization

- **Know Check Ask** is a medication safety campaign developed to support the WHO's 3rd Global Patient Safety Challenge: Medication Without Harm.
- The aim of the campaign is to encourage those taking medication and their caregivers to take an active role in managing their medication, to help increase awareness of, and educate the public about, the importance of using medication safely.
- It also encourages healthcare professionals to Know the medicines they are using, Check the details and Ask the patient if they understand.
- Supports people to be more involved in decisions about their medication, encourage them to report issues and concerns about their medication and to keep an up-to-date 'My Medicines List'.

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A Medicines List

- Everyone who takes regular medicines is encouraged to keep an up-to-date list of their current medication.
- It is a self-management and communication tool.
- Share with anyone involved in your healthcare.
- Share it with staff at all healthcare appointments.

Make it easy to use, available.
Ask for it.
Give it back!

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Keep an up to date List and Bring it to Appointments

- Resources for **lists, posters, videos** on www.hse.ie/ha/ha/meds
- List has been translated to **52 languages**
- To order copies of blank medicines lists in English, go to www.healthprofessionals.ie, sign up for an account (free of charge) and search for 'medicines'
- **Promotional video** - why and how to use a list

"Know check ask" for your safety

- Do you know your medicines? Do you keep a list? Can you describe and discuss your medicines with healthcare professionals and family when you need it?
- Get started
- Get involved
- Resources

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Do you take medicines?

Keep a photo of it on your phone

A medicines list can help anyone who takes medicines and those involved in their healthcare

<https://youtu.be/-92LfGenHbo?si=TSPHiXemibHx5eEi>

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My Medicines List

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My Medicines List - Tips

- Some people find it useful to keep a photo of this list on their phone or take a photo of your medicines with the labels in full view.
- It can be helpful to share this list with a family member or carer
- Bring this list with you when attending any healthcare appointment
- Do not assume your healthcare team member will have this information
- **Changes to your medicines?**
 - Ask your doctor, pharmacist or nurse to explain any changes to your medicines
 - It's important to keep the list up-to-date by adding any new medicines to the list or drawing a line through any medicines you no longer take

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My Medicines List - Testimonial

Peter McDonough (Double Lung Transplant Recipient)

"Such a simple tool to help me manage my various medications and really useful for my doctors" double lung transplant recipient Gordon Ryan on the advantages of the #KnowCheckAsk medicines list. Learn more and download your list here: bit.ly/2U5J8XK

In #MRI#Portlaoise celebrating World Patient Safety day, 17th September. #TSafetyHse #KnowCheckAsk

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IMSNI Best Practice Guidelines for Prescribing and Monitoring of Lithium Therapy

- **Key Recommendations**
- Monitoring at appropriate intervals
- Management of lithium toxicity
- Patient and carer information
- Local policies and procedures
- Arrangements for monitoring and communication of blood test results as well as prescribing explicitly agreed

<https://imsni.ie/wp-content/uploads/2025/07/Lithium-v3.pdf>

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Lithium Therapy Patient Information Booklet

- Collaboration between **Saint John of God Hospital Pharmacy Department**, the HSE National Medication Safety Programme, and the Irish Pharmacy Union
- **Aim:** Promote and support safer lithium therapy and empower patients to engage with their Healthcare Professional to discuss all aspects of lithium therapy, monitoring, and side-effects
- Edited and reviewed by the NALA and has successfully been awarded the plain English mark.
- Reviewed by the IMSNI, the College of Psychiatrists of Ireland and the ICGP
- Two parts: Patient Information Section and Record Book

https://assets.hse.ie/media/documents/Lithium_Therapy_Patient_Information_Booklet.pdf

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Lithium Therapy Patient Information Booklet

- Updated in September 2025 – Version 3
- To order copies of the updated booklet, please use the Smart Survey link - <https://surveys.hse.ie/s/EAFX45/>
- **Key changes**
- Indications updated to include treatment of aggressive or self-harming behaviours
- Expanded information on using liquid formulation and missed doses
- Additional detail on using lithium in pregnancy

https://assets.hse.ie/media/documents/Lithium_Therapy_Patient_Information_Booklet.pdf

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Lithium Therapy Checklist and Tracker

- Developed by **HSE Mental Health Services, Dublin North County and Dublin North City and West** to complement the Lithium Therapy Patient Information Booklet
- **Aim:** Support safe, regular and appropriate monitoring of people prescribed lithium, before initiation and at every review
- Reviewed by the National Medication Safety Programme and Saint John of God Hospital Drugs and Therapeutics Committee
- The documents can be downloaded and adapted for local use

https://assets.hse.ie/media/documents/Lithium_Therapy_Checklist.pdf
https://assets.hse.ie/media/documents/Lithium_Therapy_Tracker.pdf

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Take Home Messages

- ▶ **Unsafe medication practices and medication errors** are a leading cause of injury and avoidable harm in health care systems across the world. Most patient harm is **preventable**
- ▶ You can **support medication safety** through practicing your own safe processes and through supporting **patient empowerment** and involvement in medicines management and safety
- ▶ 'Know Check Ask' supports patient involvement in decisions about their medication, encourages the reporting of issues and concerns about their medication and using up-to-date **'My Medicines List'**
- ▶ Lithium is a potentially toxic medicine with a narrow therapeutic index and recognised adverse effects on renal and thyroid function
- ▶ Resources available to support safe lithium prescribing, monitoring and patient education
- ▶ Signpost patients and colleagues to **reputable medicines management resources**
 - ▶ Know, Check, Ask/My Medicines List – www.hse.ie/safermeds
 - ▶ HSE Medicines A-Z

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Join us in achieving... Medication Without Harm

World Health Organization

Medication Without Harm
Better Patient Safety Challenge

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Thank you!

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The PDF of presentation slides is accessible through the seminar's page on Safety Themes webpage: <https://www.ul.ie/media/60715/download>

The seminar's page on Safety Themes webpage can be found here:



Speech 2

Safety attitudes and safety culture in general practice

Associate Professor Roisin Doogue, School of Medicine,
University of Limerick

Good morning, everybody, and good morning to those who are joining us online. And a big thank you to Doctor Anna Chatzi and her team for inviting me to speak today. So, Roisin Doogue is my name.

I am Associate Professor in General Practice in the School of Medicine here and course director for the BMBS program. But my passion is general practice nursing. I've worked in the field for 24 years and it's an area where there's such growth and development in what nurses can contribute to general practice.

So today I'm going to talk to you a little bit about safety in general, in general practice, but also how it relates to the nursing profession as they develop their skill and as they grow within this field of care for our patients. And I think what's really important today, we talk about safety directly related to care we

Give to patients, but we haven't really opened the conversation around the structure, how we look at the systems within our practice. Today I want to open that conversation a little bit with you all.

So just to talk about general practice, for those who are not as familiar with the space, it's a complex clinical environment. Nurses within general practice make up about 45% of the clinical workforce and are involved in about 7.7 million patient consultations every year here in Ireland.

The role is very complex and it differs, um, depending on the nurses, what their abilities are, what their education background is. You know, there's a lot of things that influences what general practice nurses can do within that setting. So they look after immunizations, preventative healthcare, chronic disease management, lots. Different HSE services like screening, cervical screening, contraception and then there's advanced practice consultations which include assessment treatment, which includes prescribing for those who are registered nurse prescribers, referral and appropriate follow up. There's an increased demand in general practice and I think everybody recognises that not only those.

Those working in this space, but people in the community, there's waiting lists to get into practices. Our practice GPS are under increasing pressure, so working together is what helps provide the best care to our patients. The rising level of multimorbidities and our aging population also adds to that complexity.

And then of course Slaintecare, which is fantastic to see this shift from hospital based to primary care based care, cutting the right care close to the patient and making

sure that they get the full holistic care that they deserve.

Safety is a critical component of nursing practice, and nurses play an important role in identifying safety issues. So many of the practice, when I have these conversations with my colleagues at various events, they'll often identify the nurse as the person who looks at things like systems, protocols, you know, how can we better manage the workload within the practice?

Practice, they help in prevention. So again, putting together guidelines, working with the practice team so that we all work efficiently together to try and produce that best practice and patient safety event and then helping to report safety incidences across, say, the care settings.

For those again who are not familiar with general practice, I just want to introduce you to a day in my diary. Um, so this was the first week in December and I just picked at random one of my days in clinical practice. So, I work part-time here in UL and I work part-time in general practice. So, my day starts at half eight. It finishes at 6:00. The.

Evening and it has a variation of different presentations. We don't know. So, like our GP colleagues, we don't know what's coming in the door to us. It's all appointments. So, for some we'd have a fair idea. Some of them would be signposted as to what they're attending for, but it could be for our phlebotomy, it could be for a diabetes review, it could be related to blood pressure monitoring.

It could be related to sexual health screen. It could be some treatments that are coming out from the hospital that we're assisting with our colleagues in the hospital. So, some new cancer treatments and we're assisting in providing that administration of those medications. So often they're novel treatments that we don't know about. So there's a lot of safety issues we have to think.

About as we navigate our way through the day and to making sure that when I provide this care to the patient that I have all of the knowledge that I need and that I'm in the best place and that I have the ability to stop and to take a step back and take that breath.

And look for further information if I'm not sure. So sometimes a patient will arrive in and have their little medicine bag with them from the pharmacy and there's an injection in it to be administered. That's part of their cancer treatment and I've never seen it before, but my patients know that I will stop.

I'll have a look at it. If I'm not happy or comfortable or confident in the administration of this, I'll step out of the room. I'll have a chat with the GP. I'll read the administration leaflet carefully, and only then if I'm happy to proceed. In most cases, there's the similar, you know, administration technique to them, but we have that built into our practice system that we can take that step back to ensure that the patient is receiving their medication safely.

So some of the considerations that are really, really important that we think about

from a general practice point of view, and I think this is every healthcare system, it's not just specifically general practice, but I really want to open the conversation in general practice. So infection prevention and control and it's something again nurses are really good at it. They come from a hospital setting with that type of experience and look.

Looking at how do we manage that within our safe, our space, you know, how do we manage, you know, our cleaning, you know, our cleaners coming in? Is there a routine? Is there a protocol around all of that practice facilities and our physical environment? So, the hazardous materials and waste, how is that managed?

Medication safety, I talked about there. You know, something new comes into practice. We've never seen it before. Equipment and our IT system. So, one of the things that I teach when I'm teaching our medical students is about the equipment that we use. If I'm taking somebody's blood pressure, it's really important that I know that the equipment I'm using is.

It that it is validated and that the results and that I'm carrying out the procedure in the correct manner because I need to ensure that the results that I'm taking which will depend you know change the patient's course. So, we might be changing their treatment based on their results. So, I need to ensure that that equipment.

Is fit for purpose. So, I often say some like analogy of similarly if I send a blood test to laboratory that's a quality assured laboratory, I'm taking it that the result I get back is an accurate result and I'm basing a treatment decision based on that. So our equipment within the practice, whether it's a scales, whether it's a BP monitor, whether it's a spirometer.

No matter what we're using, we need to know that that same protocol is there manual handling.

Our clinical risk management, that's something that we look at a lot and it's great to have in the audience somebody who does a lot of teaching in that space. And it's something again that's so important that we collaborate together as clinicians within this space and look at clinical risk and how can we prevent and how can we, you know, look at incidents that may have happened.

Prevent this for the future, learn from it and create safer, more robust systems looking at workload management. And again, this is really, really important because often as clinicians in general practice, we just take on what comes through the door. And even though my list is full, somebody phones the secretary, say they're really unwell or.

That, you know, they've been sent out of the hospital and they need a wound care management or they need phlebotomy, John, you know, and I need it now. And people are doctors do the same, nurses do the same. They're double booked into spaces. So we're not managing our time appropriately. So again, we need to look at those systems from a safety point of view.

Staff capacity and competencies. What's the education background of the staff? Are there courses or is there education that we can support them with to better enable them to provide better care within the practice? Safeguarding of our vulnerable patient population? It could be people with different language barriers. It could. Elder.

Population, it could be people with extra needs that attend our practices, but to make sure that we are thinking about that and that we, you know, support one another within that. So, we have a very open policy within our practice, no matter how busy we are, if a chaperone is needed, you know, if there's a patient comes in to me for whatever reason, I feel that they're.

Acutely unwell and they need to be seen by the GP. We will always work together to manage all of those instances and support one another in that care.

Good communication and patient engagement in their care. And then of course, data is curiosity and confidentiality.

Having that safety culture within the practice and that, you know, wish for continuous improvement needs to be part of everyday practice. So we've a once a week practice meeting built in. Initially we're like, how are we going to fit this in? We just don't have spaces. We're overbooked as it is, but once we started doing it and putting time aside.

That dedicated time to bring any, you know, issues that might have happened, to bring these issues and have open conversations around it and always with the air of how can we improve for the next time, you know, what was the system failure that caused that to happen?

Rather than a blame culture. So, I was involved with some research and delighted with Doctor Anna Chatzi and Doctor Eugene Kil, and it was really important to look at safety attitudes of GPNS within the practices. So, to explore factors associated with safety culture and just to see, you know, are there simple things that we might do better?

To try and help with that safety attitudes, it's been recently published and the reference is at the back of this. Anybody who wants to look up that was a really, really robust piece of research. So, some of the results that came from this indicates that the length of work experience as a general practice nurse and smaller team size, so the.

And.

Less GPS and GPNs within the practice and our big mass of multi practices was positively linked with safety, better safety attitudes among general practice nurses. And if when we explored that in more detail, I think it came to the communication channels that in those smaller practices it was easier to have more open communication challenge.

And that's maybe for bigger practice, maybe to look to say, well, how can we put a

system in place to open those channels better? GPN's identified concerns with their practice and these were high workloads and clinical time constraints, the unsystematic communication methods.

Insufficient and inconsistent communication. So, we're coming back to communication again and again. Inadequate emergency training and preparedness and unsupportive teamwork. So, there's a lot of things that we can easily put in place to try and help with this.

And then the needs that they identified were structured and formalized communication. So communication again, regular and organized operational briefings. So again, looking at those team meetings and pushing them in as a priority on the calendar every week.

Frequent emergency training and clear emergency protocols and then ensuring all staff, including general practice nurses, are heard and valued, that the operationalization of the practice is not just between one or two of the partners and all of the salary GPs or the general practice nurses or other clinicians.

Are not part of that decision making process. I suppose that's something that happens with the HSE as well. A lot of communication, a lot of those conversations happen at higher, you know, GP level and the rest of those clinicians working on the ground are forgotten in asking us how will we operationalize this. The idea is great, but how do we actually put this in practice and they're the conversations we need to open.

So a couple of take home messages for you. By implementing safety strategies in general practice, it can enhance safety culture and creating a safer environment for both staff and patients. So enhancing training and mentorship.

That can contribute to clearer role definition and more effective communication.

They're the only group of nurses in the community who have no access to funded education, any education. They had a two-year pilot that's launched a care covered and they pulled the funding despite fantastic research to show the benefits.

Of education nurses to expand their practice and the benefits that are provided to general practice, to the GP colleagues and to patients. And unfortunately, that tiny amount of funding was pulled. You know, we need to ask why? Why is this happening?

Improving communication systems. So again, having those structured briefings, formal meetings where we just have conversations around the systems approach to our practice and tackling the systemic challenges. So that's workload management, role recognition and a more supportive work.

Environment. So how can we address those things?

Boosting team cohesion. So again, looking at that teamwork within general practice, looking at how do we all work together as clinicians to provide the best care possible. One of the things I'll just bring you to cast your mind back and none of us

like to go back thinking about COVID.

But when the covid vaccines were being introduced and general practice were the biggest team of vaccinators, and of those vaccinators, the biggest team were general practice nurses, they gave about 85% of the vaccines within the general practice setting and I think general practice possibly gave up to 3/4% of the vaccines. Um. 6070% overall nationally. But when that discussion around bringing those vaccines and administering them in general practice, nobody thought to bring a general practice nurse to the table to say, you know, how can we operationalize this? What are your needs from an education point of view or to support you?

In bringing these vaccines to our population. So, it's opening those conversations, bringing all of the different clinicians to the table to say this is a really important piece of work that we need to get in there and get these to the population as fast as possible.

How can we operationalize this? And when we're all at the table, we'll do that in a safe manner, both for our clinicians and for our patients.


Thank you very much and I'd be delighted to take any questions.

References:

1. Collins C, Homeniuk R. How many general practice consultations occur in Ireland annually? Cross-sectional data from a survey of general practices. *BMC Family Practice*. 2021;22(1):40. <https://doi.org/10.1186/s12875-021-01377-0>
2. Casey M, O'Connor L, Rohde D, Twomey L, Cullen W, Carroll Á. Role dimensions of practice nurses and interest in introducing advanced nurse practitioners in general practice in Ireland. *Health science reports*. 2022;5(2):e555. DOI: 10.1002/hsr2.555
3. Bury G, Twomey L, Egan M. General practice nursing: the views and experience of practice nurses and GPs in one county. *Irish Journal of Medical Science* (1971-). 2021;190:193-6. <https://doi.org/10.1007/s11845-020-02265-9>
4. McCarthy G, Cornally N, Courtney M. Role, clinical competence and the professional development of practice nurses in Ireland. *Practice Nursing*. 2011;22(6):323-9. <https://doi.org/10.12968/pnur.2011.22.6.323>
5. Kil Y, Doogue R, Chatzi AV. Safety attitudes among general practice nurses: A cross-sectional mixed-methods study. *Applied Nursing Research*. 2025;86:152026. <https://doi.org/10.1016/j.apnr.2025.152026>

Safety Attitudes and Safety Culture in General Practice

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BMBS Course Director UL
General Practice Nurse



General Practice

General practice is a complex clinical environment.


General practice nurses make up 45% of the clinical workforce. Involved in over 7.7 million patient consultations each year¹.

GPN role^{2,3,4}:

- Primary, seasonal and specific purpose immunisations
- Preventative healthcare
- Chronic Disease management
- HSE services – cervical screening, contraception
- Advanced practice consultations include assessment, treatment (including nurse prescribing), referral and appropriate follow-up

Increased demand on general practice- population growth and ageing, opportunistic screening and preventative care, chronic disease management, and a rising prevalence of multi-morbidities⁵.


Slaintecare – Shift from hospital-based to primary care-based services



Safety is a critical element of nursing practice

Nurses play an important role :


- Identifying
- Preventing
- Reporting safety incidents across care settings



0830	Phlebotomy	1300	Lunch Break
0845	CDM Diabetes + Phlebotomy	1400	Flu vaccines (5-minute intervals, 10-12 patients)
0900	Remove & Read ABPM	1500	Apply ABPM
0915	Health assessment + Phlebotomy	1515	Women's health check
0930	Hypertension review + Phlebotomy	1530	IM cancer treatment medication
0945	Sexual health screen	1545	Psychological review
1000	Primary immunisation	1600	Break
1015	ECG	1615	Asthma review + Inhaler Demo
1030	Cervical smear	1630	Diabetes review + Foot exam
1045	Asthma review	1645	Cardiovascular review + ECG
1100	Break	1700	Postnatal depression
1115	Cover reception break	1715	Cervical smear
1130	Assist with 6 week check	1730	Contact patients with results, phone consultations, return phone calls
1145	Primary immunisation	1745	Tidy-up Phone consultations
1200	Contraception review	1800	Finish
1215	Review results with GP		
1230	Contact patients with results, phone consultations		

Appointment Diary GPN

22 in-person consultations
10 flu vaccinations
8 phone consultations



Safety considerations in general practice

- **Infection Prevention & Control**
- **Practice Facilities & Physical Environment**
 - Hazardous Materials & Waste
- **Medication Safety**
 - Safe handling of chemicals/biologicals
- **Equipment, Ergonomics & IT Systems**
 - Manual handling
 - Equipment maintenance
- **Clinical Risk Management**
- **Workload Management**
 - Staff capacity & competencies
- **Safeguarding & Vulnerable Patient Protection**
- **Communication & Patient Engagement**
- **Data Security & Confidentiality**
- **Culture of Safety & Continuous Improvement**

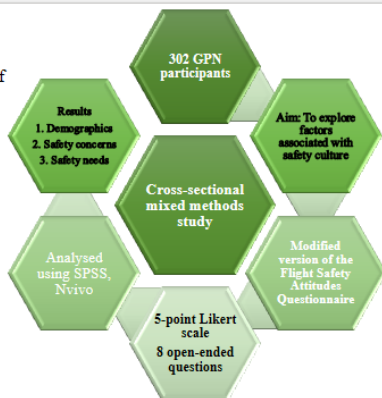


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Research

Safety attitudes of GPNs⁵



6

R E S U L T S

Length of work experience as a GPN and smaller team size (number of GPs and GPNs in practice), is positively linked with safety attitudes among GPNs

GPN identified safety concerns within their practice:

- High workload and clinical time constraints
- Unsystematic communication methods
- Insufficient and inconsistent communication
- Inadequate emergency training and preparedness
- Unsupportive teamwork

GPN identified safety needs within their practice

- Structured and formalised communication system
- Regular and organised operational briefings
- Frequent emergency training and clear emergency protocols
- Ensuring all staff, including GPNs, are heard and valued

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By implementing safety strategies, general practice can enhance its safety culture, creating a safer environment for both staff and patients.

Enhancing Training & Mentorship can contribute to clearer role definition and more effective communication.

Improving Communication Systems by developing structured briefings and formal meetings can foster collaboration and preparedness, particularly within larger teams.

Tackling Systemic Challenges including workload management and role recognition to create a more supportive work environment.

Boosting Team Cohesion to strengthen teamwork, especially in high-pressure and emergency situations.


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References:



1. Collins C, Homeniuk R. How many general practice consultations occur in Ireland annually? Cross-sectional data from a survey of general practices. *BMC Family Practice*. 2021;22(1):40.
2. Casey M, O'Connor L, Robde D, Twomey L, Cullen W, Carroll A. Role dimensions of practice nurses and interest in introducing advanced nurse practitioners in general practice in Ireland. *Health science reports*. 2022;5(2):e555.
3. Bury G, Twomey L, Egan M. General practice nursing: the views and experience of practice nurses and GPs in one county. *Irish Journal of Medical Science* (1971-). 2021;190:193-6.
4. McCarthy G, Connolly N, Courtney M. Role, clinical competence and the professional development of practice nurses in Ireland. *Practice Nursing*. 2011;22(6):323-9.
5. Kil Y, Doogue R, Chatzai AV. Safety attitudes among general practice nurses: A cross-sectional mixed-methods study. *Applied Nursing Research*. 2023;86:152026.

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 Thank You
Questions ???

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The PDF of presentation slides is accessible through the Safety Themes webpage:
<https://www.ul.ie/media/60712/download>



The seminar's page on Safety Themes webpage can be found here:

Speech 3

Patient Safety Incidents; The experience of the Patient Advocacy Service

Georgina Cruise, National Manager, Patient Advocacy Service
Ireland

And we're actually at the moment within the public acutes and within all nursing homes. So that's HSE operated, funded and also private nursing homes. And we also support people in the aftermath of patient safety incidents. We were launched in 2019 and the service was established following a patient's.

Safety incident and recommendations in HIQA's subsequent investigation into that patient safety incident, which was in 2015 and it was around maternity care in the Midlands Regional Hospital. The Ombudsman also recommended.

For a patient safety advocacy service within their learning to get better Uh report and it was about how the families were treated in the aftermath of a patient safety incident. So we're actually provided by the National Advocacy Service for People with Disabilities and we're funded through the National Patient Safety Office.

In the Department of Health, there's a commitment in our current contract which runs to 2027 to scope out expanding our services to providing advocacy within public funded mental health services. So, the model of advocacy that we provide and it's provided.

By professionally trained team of advocates, it's empowerment advocacy. So, what we hope to do is we aim to empower and support the person to realise their rights and to carry that skill going forward throughout their care. Empowerment advocacy seeks to support the person to.

Make informed decisions and ensures that their voice, win and preference are heard. I'm going on to stick in there.

That OK, that makes sense. I think it's I will put this.

You could just put that there. Yeah, that's great. Thank you. OK. Technical issues always there, not like there's any pressure standing here in front of people. So, since our launch in 2019, we have supported over 10 and a half thousand people.

Contacted our service and that's in and around concerns that they have around their care and that's in health and social care settings. 2025 was actually our highest level of contacts to date. We'd over 3000 inquiries last year and that highlighted nearly 8000 issues that people raised and we capture.

Are the issues that people raise with us using the London School of Economics Healthcare Analysis tool, which matches in line with the complaints, um, the way the

complaints are captured within the HSE, so we can kind of identify similar themes. So although our remit is currently around the public acutes and the nursing homes, anybody that rings our service gets a service. So, like that, we've also supported people. We've had over 800 inquiries that kind of sit outside that remit last year and they can raise concerns with us around the home supports.

GPS, the Primary Health care, acute and community mental health services and private hospitals. So that's amongst some of the queries we get of the 3000 inquiries that we had last year, 8% related to identifiable patient safety incidents. It's not up to us to identify.

By the patient safety incident, but we can recognize it there if it goes through the no wrong door policy with the HSE and life that what we've seen is unexpected death, baby death, medication errors, medical, surgical errors, sepsis, misdiagnosis, falls, pressures.

Ulcers and incorrect patient identification.

Through our work and experience of supporting people who are dealing with harm caused by patient safety incidents, it's clear that healthcare services and healthcare staff need to take greater action to learn from the negative experiences of people using the services.

Our work has highlighted that what most people want is an apology, an acknowledgement of what's happened, the truth and the learning, so it doesn't happen to others. As a service, we've seen the positive impact of being offered a sincere apology.

And of having an open, empathic and compassionate discussion and how that the impact of that on the compounded harm and the rebuilding of the trust in the services. We must ensure that people using healthcare services in Ireland have their voice when a preference heard and that incidents and complaints.

Plains are responded to in a timely, open, honest, empathic and compassionate manner. The really important part as well is the learning and recommendations that they're put in place, that they're there to improve practice, reduce risk and therefore harm to patients.

Independent advocacy has a vital role to play in promoting patient safety, from supporting the person or a family to navigate the complex incident management review process, ensuring they're at the centre of that process to the clinical.

And system improvements to providing that critical layer of oversight that is free from conflict of interest. We also play a role in facilitating adherence to and implementation of the legislative mechanisms, so the regulatory frameworks and the policies and procedures that are there such as the.

Patient Safety Notifiable Incident and Open Disclosure Act, the Open Disclosure Framework, the Incident Management Framework and the Open Disclosure Policy, and that's to name but a few. By gathering our data from individual inquiries, we as a

service can identify themes and recurring safety issues.

Such as communication failures and other systemic issues. Sharing this information and learning with relevant stakeholders is a key element in preventing future harm. In April 21, we signed a memorandum of understanding with the HSE.

Which is commitment from both sides to cooperate to ensure that people receive that timely, compassionate and comprehensive responses to either complaints or in the aftermath of a patient safety incident. There's also a commitment within that MOU to raise awareness of our service within HSE provided services.

But there's also the learning aspect of that where we do share that learning and that's to strengthen that coordination and cooperation when responding to complaints and patient safety incidents. We want to continue to develop that cooperation with the changes within the regional structures there.

Um, and to strengthen it for the benefits of all of those involved.

On a practical level, what we do, our advocates offer guidance through the open disclosure process and any subsequent reviews that might take place under the Instant Management framework. They're trauma informed, so that gives them the skill and active listening, and they've completed the certificate in patient safety complaints advocacy.

They're fully briefed on a person's rights during open disclosure and incident management, and we'll provide that advocacy, information and guidance. We will inform a person of their rights and what they should expect from the review process, for example, the open review process, the right to a designated person and to be involved if it's.

Appropriate in the terms of reference, we can attend meetings in relation to the incidents in a supporting role. We can help a person prepare for a meeting, ask them what they want to speak about and what questions they have. We have to ensure the process is person centred and where necessary we may provide information on.

Other services and supports that are available.

Some of the issues faced by people we have supported through the incident management process, resulting in that negative experience and compounded harm, have included no open disclosure taking place with the person or the family following an incident.

Reviews taking place and the person and their family are unaware or not being informed or invited to take part. In some key, in some of our cases, people only became aware on reviewing their own medical records. A person or a family member having to highlight a patient safety incident through the complaints process.

Or no designated person allocated when required, inconsistent communication with the designated liaison person and the review team. For example, questions submitted not passed to the review team, emails not responded to, and a person's lived experience ignored.

Another thing is communication received on anniversaries of events can be quite traumatic for people. The review process, as we know, the timeframes are quite tight, but it is falling outside those timeframes and the process being traumatic for the person and no emotional support or counselling offered.

Also, having an understanding of the incident management framework, it is a system review process, you know, and the terms of the language and the terminology that can be used within the reports can be quite impersonal, like person X and that can cause upset and compound the harm for a person.

And the knowledge that the incident happens again can also compound that harm, you know, where there's no learning from the incidents or no quality improvement. So through our model of advocacy, we were able to support people to achieve various outcomes, which not only helped them understand and resolve their issues, but also provided that opportunity for learning and improvements within the acute hospitals and nursing homes.

These included full acknowledgement with sincere apologies, policy adherence and changes, communication improvements, training and education, empowerment and emotional support and closure.

A common theme throughout our work is the importance of good communication. It is vital to reduce compounded harm, developing understanding and trust, and further the ongoing relationship.

Open disclosure is hugely important in the process. It can escalate or de-escalate a situation. Although it is mandatory under the Patient Safety Act, it really should be common practice after all incidents that that harm.

Open disclosure should take place in an environment that is conducive to that open, honest and compassionate conversation, even down to the room where it takes place, having the right people in the room who can answer questions. The process should continue throughout the investigation.

It's not just an initial conversation. Open disclosure is also having is often about having that hard conversation, and there can be a reluctance to do this. But it's only by having these tough conversations that people impacted can be shown respect and compassion. Trust can be maintained and learning can be developed.

Another area is the designated person role is actually really important. That has a huge impact on the investigation. A good communication plan with the patient or service user will really keep the person at the centre of that process.

And help them feel involved and listened to. Um and it can actually deescalate situations. Um and it reduces that harm and builds the trust.

So just some examples, I suppose case studies that highlight some of the work and the issues and the outcomes like we've seen it done really well where somebody was impacted with a delayed cancer diagnosis. There was issues around the communication around test results and I suppose appointments.

You know, and they were informed of this and they um were offered independent advocacy support or advised around us. But they were also brought in and given that open disclosure meeting where it was in a very conducive environment. The decision makers were in the room, they could answer the questions that they.

Had they could, they used appropriate language so the person could actually understand. They were involved with the review team. They were involved in the terms of reference and the parameters of the terms of reference. They saw the review report when it was appropriate.

And the causal factors and the recommendations that came out of it, they were happy with, they were informed of the implementation of the recommendations and they were actually involved in training around communication for staff from that.

And then they've also become engaged now in patient.

Partnership themselves. So, it does. When it works well, it does have a huge impact on people. We've also seen the other side, I suppose, where somebody presented to an A and E and they needed a procedure. Um, they were put up on the ward for a few days and actually there was an outbreak of COVID, our favourite thing to talk about.

When they were there, the test result wasn't given to the surgical team. The operation went ahead and the person passed, became very ill and passed away. So there was issues around the communication with the family and that I suppose the delay in the test results coming forward and.

That followed and what happened was the spouse, the person involved, approached us and we put in a complaint. We supported the person to put in a complaint and then it was picked up as a patient safety incident and followed the IMF.

Now they were happy with the outcome of the IMF. They received a full report that highlighted the errors. Um, they felt that they had been listened to. Their concerns were taken seriously. Um, but the investigation was very traumatic for the person and although they were happy with the outcome.

Come of the IMF and the recommendations there, there were issues faced by them during the IMF process, which also provide an opportunity for learning. So, the family had to initiate the complaint to the hospital to begin with. If the complaint hadn't been made, it wouldn't have been picked up as a patient safety incident.

Um, the hospital contacted the wrong person to acknowledge the complaint and to inform them about the IMF process. Um, the person they was not mentioned in the complaint, but they were a member of the extended family that happened to be in the report.

And on a known medical record, so that upset the family. The family requested medical records at the beginning of the review process and there was a data breach where there were sent records from several other patients. The family had to request a designated contact person and all information about the IM.

Process was actually provided by the Patient Advocacy Service rather than the hospital. They had to request input into the terms of reference, and while reviewing the terms of reference, they noticed inaccuracies. You know the incorrect date of birth for the person who had passed away.

The review team agreed that some of the wording in the report was very technical and agreed to use more accessible language. So say for example, the spouse found that the use of the term missed opportunity in relation to her husband's death was very insensitive.

The review team referenced several policies in the review and they had no idea what these policies were, so it was a case of requesting those policies and working with us to understand those policies.

Um, and I suppose the process didn't stick to the framework. Uh, 125 days. The process took over a year and a half to complete. And they may seem like little things, but when you combine them all together, the impact that that can have on the compounding that harm for a person, or, I suppose, interfering in the relationship. Of ongoing healthcare services can have a huge impact if it's if it's not done properly. Communication does play a huge role. It's very critical and foundational role of patient safety. The miscommunication side can lead to adverse events and patient harm, while effective communication can really prevent misunderstanding and it does build that trust.

Communication is an element of around 60% of the concerns that are raised with our service. As you can see from the above examples, breaking down the barriers through open dialogue and patient involvement is really essential for quality, safe care.

Learning and feedback that utilize the power of a patient's voice and the lived experience, which is very unique to every single person, provide positive opportunities for that risk reduction, learning partnership and that Co design piece. The process of working well when it is when it has good leadership, good communication and engaged staff, and it should empower the patient or the service user, keeping them at the Centre of the process and involved in decisions around their care, upholding their rights and listening to their lived.

Experience and engaging in continuous learning. So thank you.

Thank you very much, Georgina. Indeed, it was very interesting to hear about your work and I can express more like, you know, we're all healthcare professionals here or researchers and when we're sick and we get into the system and we experience ourselves from this, from this, we're getting the shoes of the patient.

We see the pitfalls or the difficulties of the system and that's you see a lot of, you know, articles coming up in the newspapers when you have a doctor or a nurse getting sick and getting into the system. So, it's always getting into the shoes of the patients and creating processes and systems that.

And look things through their eyes. So, it's very important work what you're doing.
Thank you very much.



Patient Advocacy Service
INFORMATION | SUPPORT | EMPOWERMENT

Patient Safety in the Community
20th January 2026

"Patient Safety Incidents; The experience of the Patient Advocacy Service"

Georgina Cruise,
National Manager, Patient Advocacy Service

1

Patient Advocacy Service Remit:

To provide a **free, independent & confidential information, support & empowerment** advocacy to users of **public acute hospitals & nursing homes** wishing to make a **formal complaint** about the **care** they have received and in the aftermath of a **Patient Safety Incident**.



2

Patient Advocacy Service


- Patient Advocacy Service launched in 2019.
- Over 10,500 people supported.
- Over 3,000 contacts in 2025, highlighting nearly 8,000 issues. 2025 had highest level on contacts since 2019.
- 800 enquiries in 2025 outside of our remit.
- Of the 3,000 enquiries in 2025, 8% related to identifiable patient safety incidents.





3

Independent Advocacy

- Support with Incident Management Framework.
- Implementation of the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023, Open Disclosure Framework, Incident Management Framework and Open Disclosure Policy.
- Data gathered, identifying themes and systemic issues. Information sharing and learning with relevant stakeholders is key in preventing future harm.
- Memorandum of Understanding with the HSE



4

The Patient Advocacy Service and Patient Safety Incidents



- Guidance with Open Disclosure process and Incident Management Framework.
- Trauma informed, skilled in active listening and have completed the Certificate In Patient Safety Complaints Advocacy.
- Can attend meetings in relation to the incident.
- Ensure the process is person centred.
- Provide information on other services and supports that are available.



5

Issues in relation to Incident Management



- Open Disclosure did not take place.
- Person unaware reviews took place.
- Patient Safety incident highlighted through the complaints process.
- No Designated Liaison Person.
- Inconsistent communication with the Designated Liaison Person and Review Team.
- Review process falling outside timeframes.
- Review process traumatic for the person
- Process is not always person centred and can lack empathy.
- Knowledge of the incident happening again – No learning from incidents or quality improvement.



6



Through our model of advocacy, we were able to support people to achieve various outcomes which not only helped them understand and resolve their issues but also provided the opportunity for learning and improvements within acute hospitals and nursing homes.

These included full acknowledgement and sincere apologies, policy adherence and changes, communication improvements, training and education, empowerment and emotional support and closure.




7

Case Study



8



INFORMATION | SUPPORT | EMPOWERMENT

Communication plays a critical and foundational role in patient safety. Miscommunication can lead to adverse events and patient harm while effective communication can prevent misunderstanding and builds trust.

Communication is an element in around 80% of concerns raised with our service. As you can see from the above example(s) breaking down the barriers through open dialogue and patient involvement is essential for quality safe care.

Learning and feedback that utilise the power of the patient's voice and lived experience provide positive opportunities for risk reduction, learning, partnership and co-design.

A process is working well when it has good leadership, good communication and engaged staff. It should empower the service user, keeping them at the centre of the process and involved in decisions around their care, upholding their rights, listening to their lived experience and engaging in continuous learning.

9



10



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11

The PDF of presentation slides is accessible through the Safety Themes webpage:
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The seminar's page on Safety Themes webpage can be found here:



Speech 4

Integrated care, Top Down, Bottom Up

Dr Siobhan Ni Bhriain, Regional Lead for Medicine, HSE Dublin and Midlands

So, Anna, just to thank Anna, uh, Jill and others who invited me here to speak today about integrated care. And I'm a consultant psychiatrist. I've worked with older people and a consultant for the last 20 years, but my current role is as the regional lead for medicine and older people in HSE Dublin and Midlands region. And I've just come from spending.

Almost six years leading the national clinical programs as the National Director for Integrated Care in the HSE Centre. So I think you'll have some sense hopefully from this of some of the work that I've done in integrated care along with colleagues, because that's not something anybody does alone, it's something you do together. And before I go into the talk, I just want to reflect on a couple of the things that Louisa, Roisin and Georgina have said about communication and about the importance and challenge that communication presents in delivering healthcare. And one of the things Georgina brought up is she talked about will and preference, and that's not something I'd intended to mention today.

I'm going to bring it up now because will and preference is the language of the Assisted Decision Making Act, which was commenced almost three years ago and which I still provide national clinical leadership for in the HSE. So, it's a subject I'm very familiar with. I think it's very important to get across. This changes the way we deliver healthcare. It's introduced.

Advanced healthcare practice in that people can now make directives as to how they want to be looked after in terms of their healthcare. But the big thing is that change in practice towards will and preference and accepting what people want and how they want healthcare delivered.

The other thing to bring up at the communication issues that everybody has brought up today, and there are many angles we can look at communication, how we communicate incidents, how we manage learning, but most of all, how we talk to each other and how we talk to the patients that we look after. And people will know there's a very public drive towards product.

Activity in the healthcare service and that is a very binary view of either you're seeing X number of patients or you're not and you have to see a certain amount of patients to be productive. But I have to say in my very considerable length of time at this stage in the health service, the more we have to spend more time with patients, I provide a consulted provided service most.

Consultants I work with work in a consultant provided way, which is very different. When I was a junior doctor 30 years ago, we had a junior doctor and the consultant very rarely seeing patients or seeing a certain number of patients mass outpatient clinics. We don't operate like that anymore and I think it will be really helpful for people like Georgina and those of us who are really.

Passionate about listening to patients and advocating for patients to make people understand that productivity does include listening and does include communication. It's not just about numbers. And I agree with you, Georgina. I think we have to be really sensitive about how we communicate those difficult issues and those sensitive issues. I certainly have been in various.

Roles as a clinical director, been that person who's had to do that open disclosure and sit down and talk to families about adverse incidents, missed incidents and sometimes death. And it's not easy. It's not easy the first time, and it's not easy the 20th time. But you do learn as time goes on.

So to get back to what I was asked to talk about, which is integrated care, I thought I'd talk about it top down, bottom up, to give people a sense of how the system has worked and developed integrated care. And this picture here is of my two daughters. We were hiking in the Julijske Alps in Slovenia last summer, a fabulous country, but we were very.

Up there and you can see more peaks and that to me is what the journey for integrated care has been about. It is a long journey.

So what is integrated care about? There are multiple definitions and multiple ways of looking at it, but it focuses. It should focus on the patient perspective and organising the principal assist service delivery. But it also does focus on clinician perspective and the systems perspectives. I'll talk a tiny bit more about that during the meeting.

It is based on the premise of illness prevention, patient empowerment, multidisciplinary cross-service planning and delivery, and where all health and social care services work together to provide a flexible network of care that is responsible, responsive to the needs of patients and their families.

WHO has provided a framework of the five interdependent strategic directions that support patient centred care and integrated health services, and that really hasn't changed a huge amount since 2015. It's still about empowering and engaging people. It's still about strengthening governance and accountability. And we've heard a lot about accountability this morning, particularly through.

Communication. It's about reorienting the model of care. And by that I don't just mean the clinical model of care, but the model of care delivery or the model of service delivery. It's also about coordinating services and creating an enabling environment.

And just very brief, I just thought I'd talk very briefly about how healthcare works in Ireland and most of you know this, but it's the Department of Health sets policy and

the health service executive's role is to set strategy for the health service and to manage budgets. It's lots of other roles as well, but we think about that department sets.

Policy, they give it to the HSE and HSE then puts the strategies in place to deliver that policy. And until last year when we moved to regionalisation, that was primarily done by the centre in the HSE, but that responsibility and accountability is now shifting out into our six regions. So, we're at a period.

Of absolutely enormous change in a health care service delivery. So we have a multi-tiered system as we know in Ireland is governed by the Health Act 2004. Some people have all their expenses paid by the General Medical Service system. Other people pay for some level of service, medication, visits to emergency departments, etc. And as any.

Of us will know who were involved in medication. That cost of your drug payment scheme has gone down over the last few years. That is all steps towards the delivery of a publicly oriented health service. Still about 46% of our population of private health government. That figure hasn't changed in many years, but the aim of Slaintecare is to drive towards a publicly.

Provided system with integrated care at the heart of its system. And so from a top down point of view, we've been talking about integrated care for years. The years ahead policy came out before I graduated when I was a medical student in 1988. We've had poor implementation of integrated care until the pandemic.

And there was the pandemic itself that highlighted those structural weaknesses and the need for greater resilience in our health care services internationally. This wasn't just a national discovery, this was across the entire health care system. And I was very involved in the delivery of the response to the COVID-19 pandemic. So, it was fascinating to see all that learning from international systems.

Coming in and seeing how we could progress our own integrated care in Ireland. So we do know that Age long Care emphasises this, that care closer to home and supporting our workforce to deliver that are key components of strengthening healthcare and improving integration.

So the key healthcare policy we have as you know is Slaintecare, Uh unique really internationally in that it's an all party agreed Uh policy, which I think is a really good thing for us. Um, the key principles are to move towards that one tier universal model, but we're still on the way there. It says we increase GP the age of.

GP visits from younger children is to the getting a little bit older, reducing those DPS. They're all moves in the universal model direction. Treatment on the basis of need really important, but increasingly challenging in the changing demographic that we have with an ageing population with multimorbid needs.

And the orientation towards primary and community care. But I think it's really important to emphasise this. While we're Orienting care towards primary and

community care, we can't forget the vital role of our acute system in delivering care for those who need it. So, there's only a certain amount of surgical procedures, for example, that we can deliver as day cases in the community.

A lot. Some of them have to be delivered in the hospital setting. Sepsis, which was mentioned earlier on, has to be looked after in the acute hospital setting. Certain conditions just have to be looked after there. So, we need to reorient towards primary and community while maintaining a focus on acute care. The delivery of integrated care is a key principle of slanted care, timely access.

And we know from the papers again and again, this is a strong focus of government, a focus on timely access and weighting this management. We're also, we've also talked about enabling environments. There's a lot of things there it's about the communication about, as Louisa said, communicating those risks, those instant learning right back to the entire system.

And I know there's a lot of work going on to do that, but it's not happening yet and there's more work that needs to be done. Uh, it's about people learning from instance, as we've heard from other people as well. And then there is a focus on the systems perspective. So, this is what I just want to bring up for people.

The patient perspective is about patient centred care and understanding what patients want from the system, but the systems perspective is about efficiency. And what that efficiency is about is reducing the number of people who unnecessarily spend time in the emergency department, people whom we can divert from the emergency department or who never go there.

Or who can be seen the following day in one of our integrated care hubs or mental health services, or whoever provides that integrated service with next day reviews. So how did we develop integrated care in Ireland? Well, we have all those policies, folks. We have thousands of pages of policies. But what really happened then over the last 10 years is that the integrated care that we're delivering at the moment was based on the models of care developed by the national clinical programmes. The emphasis was on older persons.

Chronic disease, three specific chronic diseases, heart, lung and diabetes chosen entirely because they are the most common in the population. There are loads of other illnesses that we could do chronic disease management for. We could do it for renal disease. We could do it for neurological disease. We do it for a lot of mental health disorders.

And but that is that is why those heart, lung and respiratory were chosen because they're the top causes of presentations and a burden and I just like that word on our acute hospital system. So, all of that work was combined from the clinical programs to inform to form the Enhanced Community Care program which has.

Delivered on a large number of community specialist teams for older persons around the country and for chronic disease management. They're not fully staffed, but they

are there in most integrated health areas in the country. The aim of the chronic disease management program is also to have prevention programs in progress and even when we got Roisin talked.

About when Roisin was talking about her day, we could see as part of her day as part of the chronic disease management and prevention program, which involves again focusing on those who are most at risk of developing things like diabetes, heart disease and lung disease and doing early diagnostics to try and make early diagnosis and intervene earlier. And as I said, there are a lot of areas that.

For chronic disease management, for example, renal disease and neurological disease, and there are many more that I could think of. And actually, interestingly, as care changes and moves on, a lot of cancers that previously may have had a lot of acute management people may not have survived that long from have now become chronic disease as well. So, they are managing.

Many ways by the National Cancer Care Programme as a chronic disease management model.

So bottom up, what does integrated care mean for patients and staff? Well, the people and community perspective is about quality and experience and I Posey describes it as what does it feel like for me that is for the patient receiving the service. It's person centred; it's about Co production, it's about shared decision making and all of that is supported by our.

Legislation in the Assisted Decision Making Act that we pay attention to how people want their care delivered. It supports patients' choice and self-management and really encourages self-management. Again, going back to Roisin earlier describing what happens, what nurse led clinics in general practice are about, that asthma appointment is often about teaching some.

How to use their inhaler properly so that they know how to manage their own asthma. So, we're really about supporting those things from a staff perspective.

When I say this as a clinician myself, it is about reducing admissions and supporting admission avoidance because bringing people in acutely takes up a huge amount of time from a clinician perspective and.

Quite.

Frustration when you think this person could be much better managed at home or in an integrated care hub, care hub, or for someone like myself, a consultant psychiatrist in an older person's day hospital or whatever. So, there are lots of alternatives to acute admission, but it's about looking at those alternative pathways of care. And again, from a staff perspective, when I say staff, largely clinical staff.

It is condition led and that's the perspective. But what we do need to do in between all of that is optimise outcomes for our patients, addresses what matters to the people who attend our services and go beyond individual service and condition and go beyond the individual service or condition. And that's really important again as

our demography changes and we have more and more.

People, 50% of people over the age of 50 in this country have two chronic conditions. So, you know and that increases with age. So, it's really important that we address that wider need multi condition approach to health care. I have to say if we're really doing it and where our public health care system is advancing in this way those who deliver.

Public health, they look at the wider determinants of health and what are those things get that can impact on people becoming sick in the 1st place. So that will be really important as it develops more and there are a lot of implications for our workforce and for training and just talking there about the existing models. We have professional tribes, people talk about.

Consultants about nurses, health and social care professionals. But really we need to move towards that more shared identity of what we're all in it for, which is to deliver care for patients, which I think most, which I think everybody is in health care. I don't have them come across people who aren't, but it is about developing our shared identity and collaboration and co-production with our colleagues and with users. Cares and those outside of healthcare. And we need to move beyond those educational silos, competing professional ideologies towards overlapping clinical functions, sharing our vision and purpose and towards interdisciplinary education and practice. And John Brennan, who's talking later, mentioned this in his question earlier. It's not about developing more silos.

And that is a risk with integrated care that we will develop more silos, and I have to say it is something I do think about and worry about. We do need to look at distributing leadership and expertise.

And the challenges for integration care. This is my golden retriever, Daisy. She cannot be parted from her dog toys. So, reform consists of taking a vote from a dog. Not an easy task, as I can tell you, she chewed up those ribbons before we ever got it. But the real challenges we're facing now is moving from our existing central structures. Structures to the regions and times of change are the biggest time of risk in the delivery health service. And you know, we know that from international evidence, we know it from Irish evidence. It is very important that we manage risk as we make this enormous change from central management to regional management and accountability.

For teams on the ground, it's about developing close working relationships between and across teams. And that doesn't happen by accident. That happens by people sitting in rooms, by organising these meetings, by saying we're going to prioritise meeting our colleagues in that primary care centre. And if we just talk about primary care centres, you know, I know.

Lots of colleagues who work in primary care centres, be they specialists or general practitioners, they can work in a completely siloed way unless the practice and the

clinicians, the specialist clinicians say we're actually going to prioritize meeting to discuss our common patients and it's that those kind of steps that make a difference to delivering integrated care.

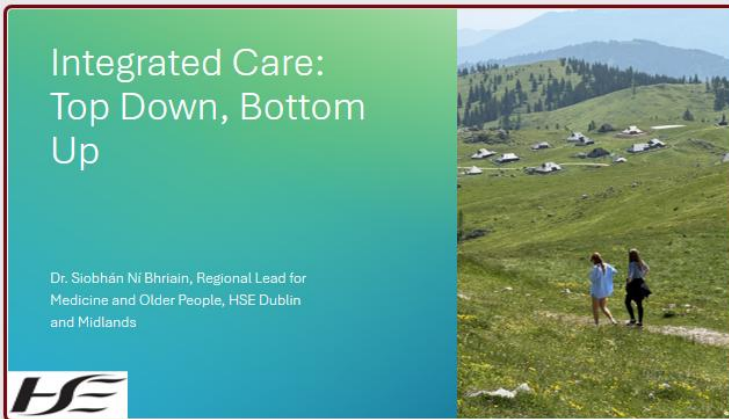
One of the things all of you will know this, we need to enable us through digital around record sharing, record sharing, data sharing that we have not got that right yet. There's a lot of work going on in that sphere, but it is incredibly important that you're going to manage patients that you've access to their data and that is not happening everywhere around the country.

The other area of risk is transitions of care between services. I'm particularly passionate about transitions of care for children to adult services and there's a lot of work that that has gone on in that area. There's a lot more work that needs to be done. But again, this is a time of risk and one of the reasons this is becoming bigger and bigger for the transitions of care of younger people is that.

Younger people with severe chronic disease who weren't living as long as they were with disabilities 10/15/20 years ago are now living much longer and need adult services and that in many ways is creating a new need and we need to work from the bottom up. So, I'm not actually finished yet because just a couple of take-home messages here one of the best.

Integrated care services I came across a long time ago was actually started from the bottom up by two colleagues, McKinney, doctors Ronan Foster and Gary Courtney and their teams. They worked together to develop an integrated care service in a Model 3 really excellent service. And I think the other thing for research-oriented audience like we have today, you'll have seen from that talk, there's a lot of.

Pinch points or touch points that we could look at research, do quality improvement on. So, a lot of areas for improvement, for consideration, for work. And just to say that that is my youngest daughter, almost 20 years ago when she started her mountain climb. She's a great mountain climber when she started off and she was practicing there. It was one of the first mountain peaks she reached when she was a. I she's about six there. So, when, as Nelson Mandela said, after climbing a great hill, we'll only find there are many more hills to climb. So that has been very much my experience of working in integrated care in Ireland. It is a journey, not a destination.



1

What is Integrated Care?

Integrated care focuses on the **patient perspective** as an organising principle of service delivery.

It is based on the principles of **illness prevention, patient empowerment, multi-disciplinary cross-service care planning and delivery**, where all health and social care services work together to provide a flexible network of care responsive to the changing needs of patients and their families.

The WHO has provided a framework including five inter-dependant strategic directions to support people-centred and integrated health services with key actions (WHO/HQ, 2015).

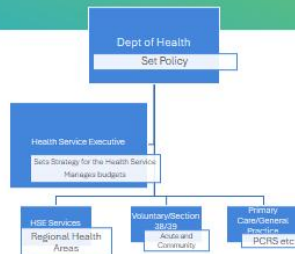
1. Empowering and engaging people
2. Strengthening governance and accountability
3. Reorienting the model of care
4. Coordinating services
5. Creating and enabling environment



2

HealthCare in Ireland

- All people legally resident in Ireland entitled to care in the Public HealthCare System
- Governed by legislation-Health Act 2004
- Multi-tiered system:
 - Public-
 - Some people have all expenses paid for (GMS)
 - Others pay for some levels of service-medication; visits to Emergency Depts etc
 - Private: Approx 46% population have private health cover
 - Aim: publicly provided health service via Sláintecare, with integration at the heart of care.



3

TOP DOWN: Policy and Need for Change



- Multiple policies aiming for integrated care since 1988
- Poor implementation until pandemic
- Covid-19 pandemic highlighted structural weaknesses and need for greater resilience in HC systems internationally
- Widespread recognition that care closer to home and supported workforce are key components to strengthening HC and improving integration



4






Health Care Policy: Sláintecare and Key Principles

- One-tier universal model
- Treatment on basis of need
- Orientation towards primary and community care
- **Delivery of integrated care**
- Timely access
- **Enabling environment**
- **Focus on systems perspective: EFFICIENCY**



Development of Integrated Care in Ireland

Based on National Clinical Programmes for Older Persons and Chronic Disease, including Heart, Lung and Diabetes


Combined to form Enhanced Community Care (ECC) which has delivered on:

Aims to have Chronic Disease Management and Prevention Programmes - well in progress

Suitable for other areas of care e.g. Chronic Renal Disease

27/30 planned Community Specialist Teams for Older Persons

26/30 CSTs for CDM



BOTTOM UP: What Does IC Means for Patients and Staff?


PEOPLE AND COMMUNITY PERSPECTIVE

- IC is about quality and experience.
- IPROSI describe IC as 'what does it feel like for me? (Irish Platform for Patient Organisations, Science and Industry)
- Person-centred
- Co-production, shared decision-making
- Support patient choice and self-management

IC should optimise patient outcomes, address what matters to people and goes beyond an individual service or condition. It can be narrow or broad and include the wider determinants of health

STAFF PERSPECTIVE


- Aim is to reduce admissions/support admission avoidance
- Provide alternative pathways of care
- Clinician-led



Implications for Workforce and Training

Existing Model

- Professional tribes/strong identity
- Defined functions-protected
- Competing professional ideologies
- Educational silos
- Uni/Multidisciplinary approach
- Clinical competence/knowledge with associated professional hierarchy



New Model


- Shared identity
- Collaboration and coproduction with others (users/carers/outside healthcare)
- Overlapping clinical functions
- Shared vision/purpose
- Interdisciplinary education and practice
- Expertise and leadership distributed



Challenges for Implementing IC


REFORM CONSISTS OF TAKING A BONE FROM A DOG-
John Jay Chapman, Am Author

- Existing structures and move to Regions
- Need to develop close working relationships between and across teams
- Enablement through digital, record/data-sharing, innovation
- Transitions of care between services, particularly for YP
- Working from the bottom up




9

Go Raibh Míle Maith Agaibh



'After climbing a great hill,
one only finds that there are
many more hills to climb'
Nelson Mandela




10

The PDF of presentation slides is accessible through the Safety Themes webpage:
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The seminar's page on Safety Themes webpage can be found here:

Speech 5

Improving safety through learning

Lorraine Schwanberg, Assistant National Director Incident Management, National Quality and Patient Safety

Perfect. Thanks, Jill, for the introduction. It's lovely to be here. So, as Jill said, I am the assistant national director for QPS Incident Management in the HSE part of the National Quality and Patients I've seen.

Always gets a bit of a mouthful, doesn't it? But our remit is very much around incident management, open disclosure and within the HSE, the National Incident Management System. So, I'm a nurse by background. I work in acute setting mostly, but yes, I suppose I have a clinical.

We were just talking about our audience today and we were quite interested, some of the speakers for the afternoon where you all work. So, I was just wanted to ask if I could maybe just get a show of hands, which of you are maybe clinicians, nurses or doctors?

Great. Oh, a large proportion. Um, which of you are maybe academics?

Yeah, it's also both. If I say which of you are QPS, I'm probably a lot of the nursing hands will go up again as well. So, thanks a million. It's lovely to be here in Limerick at the university with you today. So, my short presentation is around.

I'll just admit, um, improving safety through learning. Um, I will lean on the incident management side quite a bit. I suppose that's my area of work at the moment. But what do we mean by learning? Certainly in incident management.

We get challenged quite a bit because we're not learning.

That's certainly always saying, well, why aren't we learning? Why are these incidents still happening? So, we just talked through a few of those kind of considerations and it's wonderful to be collaborating with our academic colleagues because certainly in terms of learning, they are the experts. So, the two ideas just to think about when we talk about learning.

And quality and safety. So, there's learning as a process. So how do we actually gain that insight? How do we amass or kind of knowledge around kind of quality and safety and what do we do with that learning then? So, as an outcome, how do we drive change?

So learning as a process, in particular for incident management, is how do we approach an incident review? Like how do you understand what the kind of contributory factors are around that and what sources of information for quality and safety do we rely on?

Do we engage with service users, staff? How do we use data to really understand our system and literature and research as well? Are there innovative ways of how we kind of understand our systems to make them safer? How do we use simulation, for example, to test some of our systems?

And how do we use other methodologies, any kind of organizational knowledge and understanding? And what does the culture tell us? And how do we learn whether service is safe? And then when we have that learning, what do we do with it? And this is probably one of our challenges. So how do we know when we come up with our recommendation?

How we act, how we implement, how do we adapt and reinforce and how do we share and improve? Sometimes that's quite a little bit of a challenge to demonstrate in incident management and I'll speak to that a little bit further. So, I suppose taking an international approach around quality and safety, one of our kind of.

Documents that certainly at a national level and with the National Quality and Patient Safety team at the Department of Health have. Am I speaking loud enough? I think my wonderful voice transcends. You know, I know I'm quite croaky, but.

So globally, there's certainly some kind of strategic objectives that are kind of being put forward in terms of how we should approach quality and safety, what are those kind of underpinnings? And it's quite nicely mapped out in this global patient safety action plan that we're all meant to be driving and implementing.

And actually when you look at some of those structures that underpin this global patient safety action plan, there's some elements that should resonate with us that should that we are working towards as well. In particular, I know it's in small print, but you see at the very bottom those.

Triangles kind of building up the structure. There are some of the strategic objectives within the global the World Health Organization's Global Patient Safety Action Plan. So, it's really trying to get organ countries across the globe to develop policies to limit.

Eliminate avoidable harm. So what can we do to reduce the likelihood of harm occurring? They speak about high reliability systems and organizations. Have you heard of that language before? What's a high reliability organization?

So they often use that term for some of our very high risk industries, so the nuclear sector flying and that. So, there's a lot of risk, but actually the frequency of very serious incidents is very low and some of the reasons underpinning that is that they take even the smallest incidents quite serious, investigate them really.

They really try and understand their system. They have a just culture within them, they encourage reporting. So, there are a lot of mechanisms and healthcare. We would like to be a high reliability organization and we would like to move in that direction and certainly for us that would be an aspiration to achieve that.

Sometimes they say there's more complexity because of the human factor and

elements around healthcare industry. But there's certain, certainly a lot of similarities and you know, a lot of emphasis in building a just culture within the healthcare system. So, safety of clinical processes, patient and family engagement, we heard quite a bit.

About that, certainly in the incident management framework, which is being revised at the moment, there's going to be a big chapter on meaningful involvement of the patient and family in the incident review process. So, we're moving with this kind of direction, international direction as well because we know it's the right thing to do. And then obviously having a skilled workshop, information, risk research and risk management. So again tapping into resources like EQUIPS and other even HSE library, how can we use that knowledge and then partnering and collaborating and we've heard quite a bit about that as well, that integrated approach.

So this is a kind of international vision for us in the kind of, I suppose in particular my world, in our world and incident management learning is a key feature and features in the Global Patient Safety Action Plan as well.

It is one of the six principles around incident management. So, we say if we're doing good incident management, it will lead to learning. So, learning as a process in terms of undertaking the review and then doing something effective with that outcome and the findings of the review.

So it's one of six principles. The other principles are around being open and transparent, being responsive, leading to improvement, and the other ones actually escape me at the moment, but I've been writing them in my revision of the IMF quite a bit, so.

Test me on that again later. So this is our process in terms of how we gather our learning from incident management. It's kind of a step-by-step process and you can see with the kind of first step in terms of incident management, it's around risk assessment and incident prevention and then when an incident occurs.

Takes it through that kind of quite mental model, which is quite linear. And actually when the incidents are quite complex, we know that they're it's not as linear as we would like to like it to be. Sometimes it's probably nicer laid out on the paper. It can get complex, but the key steps are around taking immediate actions to prevent the incident.

From occurring again and then initial notification and reporting, assessing and understanding what happened, happened and analysing that and then obviously having your review findings. OK, so if you're doing that well.

Then you should have a good understanding of why the incident happened, OK.

One of the key areas that you might be familiar with as well is a kind of safety 2 lens as well in terms of learning from excellence and we're hoping that that will feature in the next IMF, which will hopefully be out this this side of the summer in any case. So, it's not just focusing on when an incident happens and things go wrong.

But it's actually learning from teams where something worked quite well and we actually know that our staff are extremely well versed in kind of mitigating against risk and actually largely prevent incidents. So, we do really want to learn from teams when it works well or from individuals and trying to understand those actions. And mitigations as well. OK, well, at least it's quite motivating and actually puts a positive lens on, uh, learning as well, OK.

So in particular around incident management, we have your individual incident, which gives us great insight as to why an incident might have occurred, but there's a collective data as well. Sometimes there's a challenge around incident data and there's not being the best measure because there's lots of influencing factors.

Is around incident data, what's the culture like with an organisation? So just because they have low incident numbers doesn't mean that they're necessarily safe. There might be culture where it's quite oppressive in terms of incident reporting and that, but generally collectively and a kind of pool of incident data.

Does help with surveillance and picks up on some incident trends as well and you see some of the strengths that and weaknesses in terms of how to apply that incident data. So generally, for trend analysis and surveillance it can be quite good. We do report around 200,000 incidents in the HSE.

A year. So there is a large pool of insight there and then it also can be used for performance assessments and certainly in certain areas in particular if there are issues around access and maybe in service access and operational pressures as well to kind of correlate if there's harm occurring because of those types.

Of events and that and then breakdown and resilience, whether there are any kind of issues in terms of the kind of safety barriers that we have put in place and whether or not they're not effective, even though we think we've put in some very robust measures.

And then also it can be used for new and uncommon sources of serious harm. So that's where you would use a more in-depth analysis. OK, rather than that pool data, it wouldn't give you that much insight. You really want to understand why that has occurred.

So just to touch on, I suppose we've kind of gone through the process and I know this is very high level in terms of how we ascertain what the learning is. So we've got a lot of insight from lots of different sources. Incident management, you could have done a quite a robust review where you want to understand that, but when you actually come to your findings and trying to make a.

Change and kind of moving into that learning as an outcome space and how you kind of prevent incidents from reoccurring. Again, it's really important to be mindful of the kind of recommendations being put forward and how effective they are. We know that generally.

The recommendations and actions we take that maybe will design um out a

particular practice or process um are the most effective in particular mechanical barriers. So, you know some of our kind of connector type um.

Preventers, so we can't connect, can't use an oral syringe to give something IV for example, and that are the most effective. But in healthcare we do tend to lean on the administrative barriers to prevent incidents quite regularly. So, we'll develop new training programmes and SOPs or.

Policies, but there are quite a few weaknesses with those preventers, really. So, whether staff actually understand them. I know we had an incident one time in a very large organization, but it turned out that there were five SOP S for the same procedure and staff were just following different procedures and things like that. So just.

To be wary, education policies, and that's obviously important, but they should complement whatever else. And the most robust mechanisms are to design safety into the system. So, for example, if you're in a particular environment, you kind of designed risks out.

Preventing harm. Now this is probably a very outdated picture and I'm sure there's probably some risks in that with this environment, but it's just looking at the design and making this design safe. Now this is from an acute setting. It's just my own experience, but just to give you an example, so.

2 minutes. OK, I'll give be very quick. So, for example, in an acute setting, you might have an oxygen air outlet and an air outlet, and there were particular incidents occurring whereby patients in a resource situation were connected to air instead of oxygen. And obviously they required the oxygen in that particular.

Scenario. So, they came up with some great inventions. Make sure the labels are bigger. That will definitely stop the incident from occurring. Limited effectiveness actually raised awareness and more incidents were being reported. The main solution that really helped was actually when they put a kind of a barrier in a kind of a cap that you.

Needed a key to be removed and that stopped the incidents. OK, so look at those kinds of mechanisms, how we can create a safe environment. When you do come up with recommendations, that's not the end of your kind of learning. Test those recommendations. Are they effective? Are there any unintended consequences? Look at your assurance piece and I know I'm sure Magella will touch on.

Some of those elements as well, some of the kind of challenges that we know and I don't know why the print is so small there, but you will get the slides. So, some of the challenges in actually affecting that changes around quality of recommendations, not having the kind of resources to implement them effectively and to check their effectiveness.

And there might have been lack of engagement with developing the recommendations with the people who actually work in the area. So, involve those

people in designing and coming up with recommendations and there might be some organizational challenges with implementation as well. Lastly, in terms of learning and this is what people always think.

It's a really important component, but it's how do we actually then raise awareness about some of those findings? How do we share learning within the HSE? So the national level, we've developed Patient Safety Together, which is an online platform where we share a lot of learning and relevant for the community topics as well. For example, we have a patient safety digest that we produce with the HSE library that we issue every quarter. It will give you a summary of the most recent publications at our human factors system thinking and that's it's a nice summary that you can bring to your teams.

We issue a HSE national safety alerts which are focused on particular safety risks and give kind of mandate actions from organisations and that they are produced with subject matter experts. We try and limit those because we don't want to saturate the system. So, one of the alerts we issue.

Recently was around the introduction of NR Fit connectors, which is a countrywide was again a change project. NR Fit is a particular.

Connection which prevents inadvertent connector connection of spinal fluids and medicines and that. So, and then we have patient safety supplements again which have a more narrative topic that we cover where we share learning and again that's produced with subject matter experts. We have a patient.

Safety community, if anybody's interested to join that as well as particularly for staff, it's kind of a safe space and we have quarterly virtual events where we've covered a lot of community focused topics such as.

Suicide, mental health, medicine, safety and transitions of Kirk have come up there as well. Most recently we did a thematic analysis around all the incidents reported around choking incidents.

Labor disability service and residential settings and we produce a number of little outputs for that. So, we have the one page poster that you can hang in all your kind of areas and we have a more detailed thematic analysis for staff that might be working in QPS and that. So that's all available on our website.

And it's really for you to think about as well. So, there on the website, we've done a nice project that we got funded by the Q community in terms of actually getting that learning from the front line. And that's really where we kind of, I suppose, rely on some of you interested colleagues to bring that learning.

The front line, but also to engage with us in particular patient safety together. If you see particular topics that you feel warrant national attention, please do get in contact with us and we would be very pleased to develop those with you as well, OK. Thank you.

Improving Safety through learning

Lorraine Schwaberg – AND QPS Incident Management
EQIPS Research Network. 20 Jan 2026

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1

In safety, what do we mean by learning

Learning as a Process

- How do we learn:
 - Making inquiries from many sources (service users, staff, data, incidents, complaints, literature, etc.)
 - Innovative ways of seeking understanding – simulation, FMEA
 - Organisational knowledge and understanding
 - Culture

Learning as an outcome

- What do we do with learning:
 - Act
 - Adapt
 - Reinforce
 - Share
 - Improve

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2

The GPSAP 2021-2030 was adopted by the 74th World Health Assembly in 2021.

The WHO committed to eliminating avoidable harm in healthcare globally over a 10-year implementation period.

Focus is on incident learning, openness and transparency, engagement, no blame culture.

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3

Global Patient Safety Action Plan 2021-2030

Vision: A world where patient safety is a reality

Mission: Reduce global patient safety incidents and harm

Goal: Address the root causes of patient safety incidents

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4

IM Principle

Learning

- That the incident management system is focused on learning both locally and within the wider service.
- That there are a range of tools and methods used to share learning from incidents at local, directorate/service and organisational levels.
- Where feasible, that learning from incidents is considered alongside other sources of quality and safety information to inform improvement strategies

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Incident Management Process

No. 1 Learning as a Process

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6

Learning from Excellence – Safety II

7

Learning as a Process

WHO 2020 Patient Safety Incident Reporting and Learning Systems

ACTIVITY	SOURCE OF ANALYSIS	STRENGTHS	WEAKNESSES
Surveillance	All incident types	Highlights local problems and trends	Weak on systemic analysis, little accountability attributable
Performance assessment	Incidents involving particular risks of care	Creates opportunity for system redesign and empirical safety within a field of care	Minimum evidence further knowledge to assess nature of performance weaknesses
Breakdown in resilience	Incidents, identified as breaches of standards or control measures	Enables correction of errors or deficiencies	Caution can be made regarding and initiating action complex
New and uncommon sources of patient harm	Incidents of novel type (showing divergence in how and where)	Provides opportunity to think beyond routine problem	Needs highly skilled people and data

Source: World Health Organization

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HE Hierarchy of Controls

Nick Sevdalis

9

HE Hierarchy of Controls as applied in healthcare

Nick Sevdalis

10

HE Design

Nick Sevdalis

11

HE Finding a Solution **! Patient Safety Alert** Reducing the risk of oxygen tubing being connected to air flowmeters 4 October 2016

Figure 1: Oxygen flowmeters (left) are usually white and medical air flowmeters (right) are usually black

Nick Sevdalis

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HE Barriers **! Patient Safety Alert** Reducing the risk of oxygen tubing being connected to air flowmeters 4 October 2016

Nick Sevdalis

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HE Collaborative Working with 100+ Healthcare Organisations
National Quality and Patient Safety

PDCA/Deming Cycle

SMART (specific, measurable, attainable, realistic, and time-sensitive)
Simulation
Working groups for on-going improvement
Assurance - Audit/Score card/outcome measures

Nick Sevdalis

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Factors affecting the application of learning

- Quality of recommendations, too many or too much detail or too simple, do not address the issue
- Resource – workload, time for training, staff turnover, lack of front-line engagement
- Lack of engagement with front-line staff in identifying recommendations, lack of communication re the need for change
- Organisational issues- spanning boundaries of speciality, complexity, lack of quality assurance processes

Anderson et al 2018

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No. 3 Sharing Learning

HE Patient Safety Together: learning, sharing and improving

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patientsafetytogether@hse.ie

Patient Safety Digest
Listing of recently published QPS journal articles & reports relevant to anyone with an interest in improving patient safety.

HSE National Patient Safety Alerts
High priority communications requiring services to take specific action(s) to strengthen patient safety.

Patient Safety Together:
learning, sharing and improving

Patient & Staff Stories
Learning from the experience of Patients/Service Users & Staff through stories and videos.

Patient Safety Supplements
Sharing relevant QPS information in a timely way for learning purposes

Patient Safety Community
National community hosted by 'Q' to enable staff working in QPS to share learning and to provide peer support and networking opportunities

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Communication Channels

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HE Healthcare Professionals Open to Help/Work for Other
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The PDF of presentation slides is accessible through the Safety Themes webpage:
<https://www.ul.ie/media/60717/download>



The seminar's page on Safety Themes webpage can be found here:

Speech 6

Quality Improvement in Action in Community Services

Majella Daly, Assistant National Director, National Quality and Patient Safety

Thanks very much Jill and good afternoon, everyone and thanks very much for the invite to come along and present here this afternoon and welcome to everybody online as well. So, I work with Uh Lorraine and I work with Louisa who spoke this morning as part of the quality and patient safety team with Doctor Orla Healy nationally and I'm here today just I suppose to share some of the work that we do under the function of audit, improvement and education and disclose. The good news is from my perspective, I can see lots of opportunities for quality improvement in action in the community and hopefully I can share some of those examples and maybe inspire you to take some of that back to your workplace. So, it was good to see the large number of clinicians that are here in the room from the earlier show of hands. So just a little bit about national quality and patient safety and Quality Improvement and what we can do to support you and what we are doing. And I suppose just understanding that in light of the reform structures that Siobhan talked about earlier in terms of the role of NQPS in the HSE Centre, but also in line with the regional structural.

Changes that are happening both from a clinical governance perspective and a quality and patient safety perspective, just a little refresh on understanding some of the steps with QI. Some of you may be very familiar with it. So just a refresh on some of it, some of the examples in action and then signposting you to some of our further education and training materials that are available to you.

So within Centre, we have a wide brief I suppose in terms of what we do, but we're very much in the enabling and the assurance function from an NQPS perspective right now. So, from some of the examples from enablement perspective, we produce lots of guidance. So, for example our clinical audit practical guide.

Recently we published updated guidelines for sepsis and we have updated Uh training packages for sepsis and we'll have a new sepsis training package coming out for non acute settings. So, there are some of the examples of the enabling functions that we have within the centre.

Uh, from a clinical audit perspective, we also Commission a wide range of national

clinical audits and also support Uh local clinical audits in terms of guidance, education and so on. And I suppose from the community perspective, it's useful to know what's happening from a national clinical audit and registry perspective. So, the boundaries are starting to be pushed.

And uh, so some of our new and emerging national audit and registries are National Dementia Registry is commencing and that work has been commissioned with NOCA, which is the National Office for Clinical Audit. And there's also work commencing on the establishment of a diabetes registry and obviously that will look at the integrated pathway of care for patients.

In acute in our new chronic disease hubs and in primary that's been led out within the HSE and the clinical lead for that is Doctor Sean Dineen. We have other registries in development for cerebral palsy for example. So again, this will target individuals within our disability settings in primary care as well and also.

Palliative care. So, some of you may be familiar with the palliative care outcome measures. They've already been in place for a number of years, but that work has now been undertaken in conjunction with NOCA. So that of course will be of interest to the Hospice community and to palliative care services. So there are examples of some of the programmes of work that we're leading on from a central.

Perspective. So, within Uh QPS audit improvement and education, we are about, as I said, building skills, knowledge and confidence in improvement methods. So some of our programme work streams link with the common causes of harm that are identified in our HSE Patient Safety Strategy 2019 to 2024 and that strategy obviously is up.

For review and Uh refresh and that will that programme of work will commence this year and obviously we'd be looking forward to having engagement with people such as yourselves in the development and update of that strategy. So, some of the areas of work under that are substances, as I mentioned, medication safety with Lu, which Louisa talked about this morning, wound management.

And we're also now looking at the area of the deteriorating patient improvement programme. So currently we're undertaking a survey, particularly with the acute hospitals at the moment, looking at early warning systems and how effective or ineffective maybe they are. There's obviously areas for improvement and early warning scores are also in development in older person services at.

At the moment with the iRestore project, which some of you may have heard of and we're aware of within disability settings, they're also starting to look at early warning

systems for development there as well. We deliver QI and clinical audit capacity programs, self-directed e-learning modules and look, I'll signpost you to all of that at the end.

So just a little refresh on what quality improvement is and look, you know, we're here today obviously to talk about it in the community setting, but the same principles apply whether you're undertaking quality improvement in acute settings, Uh or in community settings, as I said. So look, all improvement requires change, but not every change is an improvement and I suppose lots of you can think.

Examples of where something was introduced in your care setting, but actually did it lead to an improvement for you as a staff member in terms of approving the efficiency of how you deliver the care to the patient, or indeed more importantly for the outcome of the patient, maybe it was a new checklist was introduced.

A new policy was introduced, but actually had people tested that. We're going back to that test of change that Lorraine mentioned earlier. So, so considering that not every change is an improvement and if somebody new comes in with an idea, it may not be best. So, applying the rigor of the theory of quality improvement to test that change is important.

So it's the combined and unceasing efforts of everyone. And we talked a lot this morning about, you know, that interdisciplinary working and that no one person, no one discipline should be working in the silo and trying to make changes themselves. It's very much having that team approach and that making changes should lead to better patient outcomes, better experiences of care.

And continue developed and development and supported staff. As you can see there, it's a cyclical approach. So, the good news with clinical or with quality improvement is continuous is you know you pick one topic, you may address the problem and the change may lead to a positive impact for the patient, but then you have to move on and there's all.

Was something new to pick. So, it's systematic, it's coordinated. It is there to help you solve problems. So, we all identify problems. I'm sure you could think of three off the top of your head straight away about problems, but it's a technique and a way of trying to address those problems to bring about improvement.

I think it's useful just to settle in the context of what we call a learning health system. Obviously, Lorraine's just shared a lot of examples of how we're trying to learn from incidents and near misses and so on. And we have a really nice QPS talk time from Doctor Tom Foley, who's a CAMS consultant in in Donegal, gave last year.

And he talks about a learning health system in which internal data and experience are systematically integrated with external evidence and that knowledge is put into practice. And as a result, patients get higher quality, safer, more efficient care and healthcare delivery organizations become better places to work. So, I think that's what all of us are trying to do. We recognize the organization.

We're working in very complex, very complex systems. We're dealing with lots and lots of staff. So, we're trying to look at data, but also using the experience and knowledge of the people that we're working with to try and bring about improvements. Just a moment to mention the difference between clinical audit research and quality improvement.

All inextricably linked, our research community is here with us today. So working with our research partners, we want to find out well what is best practice and then using that information from our research we can put in place our evidence based standards and then what we need to do is measure and that's in the form of our clinical audits to see are we meeting those.

Standards or not, and usually then after a first cycle of audit, we're going to have to put in place quality improvements. So, the three are inextricably Uh linked, but different at the same time. So when you're undertaking your project, it is important to know which one it is because different Uh rules that supply.

Also just important to refresh and we talked about this this morning a little bit about safety of care, effectiveness of care, efficiency of care, you know, this constant drive that seems to be within the HSE now around productivity, efficiency and so on. But we can't only have a lens on efficiency. We have to really make sure that the care we're delivering is safe.

Other.

It's effective in line with our evidence based standard and really, really important Uh patient centred care and the lead for the Iris store project gave a really nice example at a talk recently where you know they were looking at the soft signs of deterioration of Um you know clients in older personal services and one of the soft signs for one of the residents in one of the pilot sites was.

Know this particular resident really took care of herself. She liked to put her curlers in her hair every night and paint your nails. And one of the soft signs for that individual was she didn't put the curlers in her hair that night going to bed. She didn't paint the nails. She wasn't as conscious about her appearance. So that for her was her individual patient centred indicator to the staff that things.

We're just starting to offer that individual. So, it's really important that in the midst of all our evidence based standards, we're still thinking of how that applies to the individual in front of you. Those domains of quality reflect onto our equational standards and obviously those standards are in place.

Across our acute services, but also obviously in residential services for old people and disabilities. So, you can see how they reflect and obviously those standards are evidence based as well and we do measure against those standards or you measure against those standards in community services as well.

Um, lots of approaches to quality improvement. Uh, some of you may be familiar with lean, some of you may, uh, be implementing 6 Sigma in your work practices. For us in the HSE, our focus is on the model of improvement. Uh. So, a lot of our Um guidance documents and training is based on this and it's very much about, well, what are we?

We're trying to accomplish though he set smart objectives and aims. How do we know that that change is an improvement? So we're going to have to have some level of measurement in there and what change can we make that can result in an improvement, a sustained improvement and again using the PDSA cycle and Lorraine mentioned that in terms of your recommendations and trying to implement.

And again from a QI perspective, you know this is the theory, you know, rather than jumping in and you know, identifying a problem and trying to immediately run to solutions for that problem that you take this step-by-step approach. So, this theoretical model applied in whatever setting you're working in will work.

Identifying what your quality issue is, understanding your problem, developing a strategy and change idea, measuring for improvement, that small scale testing you do using your PDSA and then sustaining and spreading that change and improvement. So again, people often say, well, where do I start? What do I identify as my opportunity for?

Improvement. So again, all of these will apply no matter what setting you're working in. We talked about safety audit results. So, looking at maybe if you are working with data from national audits and you talked about you know data that might be available from population health perspective like we have huge data sets available from NOCA from the Royal College of Physicians who undertake.

Quality improvement programs for us, et cetera. Are you using that data that's available to you in your setting to generate areas for improvement or from your local audit results? And there's other opportunities as well, feedback from our patients, be

it positive feedback or negative or from families, are these identifying areas that we may need to improve?

So using data, using hunches, using Um reports, I suppose that we receive from HIQA, from the Mental Health Commission in terms of any of our regulated services, are they identifying areas where we need to make improvements? And then obviously research, maybe attending conferences, events such as today where you hear.

Uh, about initiatives that were taken undertaken in similar settings to yourselves. Are these giving you ideas for quality improvements? And then some of the tools to understand the problem. And again, you can use these tools, I suppose, for root cause analysis of incidents, et cetera as well. So, your fishbone diagram, your five whys.

If any of you have children, all of you will be very familiar with the five whys and they really want to drill down and get to the root cause of the problem and other tools as well. And all of these are available from our QPS toolkit, which I'll signpost you to in a moment. And leadership. Look, we can't do any of these this without people at the end of the day.

We must be the most people intensive industry going. All of our services, all of our systems are delivered by people. Yes, we have equipment, yes, we have medication, but we are the system that are delivering the health care to our patients. And without that, without leadership and all of us here in the room can be leaders, we can't.

Influence that change for improvement. Quick question. If you were trying to engage staff for improvement, what do you think? Oh, I've got the percentage up there. It was actually a question. Bad slides. OK, so anyway, 5% of our decision making comes from the head in terms of our logic and our understanding, but actually 95% comes from the heart, comes from the gut.

Instinct.

So if you're trying to influence staff in your area to make change, to make quality improvement, I always use that within model, what's in it for me? So start there and try and understand where they're coming from. I suppose we think recently in the HSE, NiSERP was introduced and a lot of people for maybe if you aren't working the HSE, basically it's new HR.

System where you can enter your annual leave and your travel and so on. And a lot of people were resistant to that and it came from a place of what's in this for me? Is this going to make it more difficult for me to apply for my annual leave? We're

probably all familiar with the innovation distribution curve, the laggards and the innovators and you know, depending on fortunate.

Should of.

You're trying to introduce and implement. I might be a laggard one day, but I might be your innovator the next. So, I'm not always necessarily the laggard. All of our patient safety improvement priorities are listed in the in the patient safety strategy. Just a reminder again from a community perspective across older persons, mental health services, disabilities, public.

Public health nursing, you all have quality care metrics. They're a really good starting point as well in terms of collecting data for improvement. And they're again across a wide range of topics, but linked to common causes such as your pressure ulcers, wound management, etc.

Um, signposting you to some, um, a nice little YouTube clip that we developed a couple of years ago as part of Clinical Audit Awareness Week where we had shared examples from staff working mental health settings in the Southwest and it was on foot of the mask you report and the numerous recommendations that came out of that that people undertook.

Quality improvement initiatives in their own services linked with medication, linked with patient reported outcome measures and similarly in intellectual disability services where we're using information from our HICWA reports to implement quality improvements. Um, this is another example from Clinical Audit Awareness Week last year and Twilight.

Set in the ED department was around the identification of delirium, ensuring the patients went on the correct delirium pathway when they came into hospitals. Suppose what was interesting about this was the human factors approach and how incorporated that into their quality improvement. So you can read this slides will be shared with you afterwards. Obviously, there's too much text, but just to.

Give.

Some examples, other examples, clinical handover again while in a hospital setting, clinical handover is really important no matter what setting you're working in and just some of the learning from QI. Again, it was about engaging with the staff, bringing on board the NCHD's, ensuring that there was face to face handover, but they were involved in solving the problem around that as.

As well and DNA's, I'm sure we all experience DNA's no matter what setting you're working in. Again, some examples of how people implemented QI working with the staff to identify what those QI projects should be. And then more recently in Clinical Audit Awareness Week, we had a presentation from one of our chronic disease hubs in Kerry.

Looking at cardiac rehabilitation patients in terms of whether they achieved their BP, the correct BP when they were going through the rehab program, they introduced change where they introduced home BP monitoring because of the white coat syndrome in the clinic and again that was positive and the results from the re-audit showed positive impact there.

So just some examples, but I suppose the key themes coming out and they've been coming up throughout the entire day is about frontline staff initiative and engagement. Really, really important. You know the problems, but staff of the frontline also know the solutions. So really important to engage them that it's multidisciplinary. So, it's not the nurse have always having to take the lead.

Or the radiographer. I'm from a radiography background that I'm not the one having to take the lead that it's taking that into multidisciplinary approach, education and communication that we set clear measurable goals, sustained and monitoring is in place and data-driven intervention. So, I suppose always with quality improvement we're going to have to have some level of measure to assess whether we're achieving our.

Goals and the only impossible journey is the one you never began. So, all of us today leaving the room in terms of a take home message is, you know, what can I do back in my workplace today? Have I another minister to just to signpost to some of our resources? Um, so we will have our new QPS um prospectus coming out this week. And that does signpost lots of the QPS education that's available. Human factors was mentioned this morning. So, we do have an introductory module on human factors. We have guidance on human factors, but it doesn't just cover the education that's available from the central and QPS team. It's wider than that, it's lean, it's risk management, etcetera, and it's linked with our quality and patient safety.

And Competency Navigator would really like people to start using that particularly as maybe as part of your performance achievement. There's lots of opportunities for learning there linked with quality and patient safety. And again from an education perspective, we have an introduction to quality improvement on HSE land and again if I was giving you a take home message, it's 1/2 hour.

Module, maybe it's something you could consider doing in a team approach and it just gives you that general introduction and it might stimulate and be as for how you can work together for improvement. We have the foundation. We've also been introducing quality coach development program. It's in its third round now led by uh Juanita Guydra and that's about.

Skilling up people in coaching skills for Qi, so working with people, um to enable them to come up with Qi suggestions and support them through that. So that's, uh, been positively received at the moment. And then we have some of our in-depth QI programmes such as the programme that John assists with, uh, the RCPI, uh, cert in QI leadership.

In the RCPI and the SAFE program, etc. These are our tools and guides that are available on the HSE website. Then from a community perspective, just to signpost you to the new clinical resource pack for pressure ulcers and for lower limb ulcers that was published in November of last year. And again, there's audit tools.

There's lots of guidance documents in it for staff and for the work that's happening with the Wound Management programme in terms of developing standards and we're working in collaboration with the ONMSD who are currently planning to update the Wound Management Guidelines 2018, also signposts new to our Quick Patient Safety mobile app and.

That is information up there around again 2 common causes of harm, falls and pressure ulcers. We would like to do more in that space for sepsis, et cetera, but just there is a lot of information there for staff in all settings. Uh, so if you haven't downloaded that app, please do.

Again, Q Community was mentioned. Uh, really helpful, vibrant community across Ireland and the UK. So again, free to join and Uh can introduce you to others who may be working in a similar space to yourself. A Walk and Talk Improvement podcast again podcast there on Human Factors mentioned this morning, but multiple other podcasts from a staff perspective.

Perspective and John, I think you have a podcast up there from the past as well and here's the Um QR codes to all of the various information that we have such as clinical audit etc. And just to signpost to some of the upcoming events that you may be interested in submitting abstracts to or attending because again it's a learning and sharing opportunity, so the no.

So the NOCA conference coming on the 10th of February and I think they're still open for abstracts. And what's heartening to see at the NOCA conferences in recent years, it's moving away from not only having abstracts in hospital settings, but certainly the community are starting to have more of a prominent feature as well and ISQA is also coming up.

Then at the end of September, and that's an international conference. So and finally, this is my thought for the day. Look, every accomplishment starts with the decision to try. Uh, so that would be my one message. Go away. Think about how you might solve problem solve in your own area using quality improvement, uh, methodologies. And uh, be delighted to hear more from you and uh, work with you to support you. So, thank you.



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EQUIPS/UL Patient Safety in the Community

Quality Improvement in Action
Tuesday 20th January 12:50 – 13:10



Majella Daly
Assistant National Director, Audit, Improvement and Education
HSE National Quality & Patient Safety

1



Learning Objectives

- Role of NQPS in Quality Improvement - what we do to support you.
- Understand the steps involved in QI with some practical tools
- Examples of QI in action
- Recommend further educational and training resources for QI that may be utilised in healthcare settings.



2



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3

The QPS Audit, Improvement and Education Team

We work with individuals and teams to design and deliver programmes and resources aimed at building skills, knowledge and confidence in using improvement methods to address patient safety priorities. This enables our health service to deliver better care and outcomes for staff and patients.

Principal focus: 13 common causes of harm outlined in the HSE Patient Safety Strategy DPIIP, Sepsis, Medication Safety, Wound Management.

Programme workstreams:

1. Delivery of Clinical Audit and QI capacity-building programmes, including: self-directed eLearning modules, online and virtual workshops, QI project clinics, advising on programmatic approach to QI.
2. Co-design, testing and publication of evidence-based Clinical Audit QI tools and resources, designed for an Irish context.
3. Connecting and building professional networks for enabling and enhancing Clinical Audit and QI at all levels.

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Quality Improvement

5



What is Quality Improvement?



"What if we don't change at all and something magical just happens?"

All Improvement requires change... but not every change is improvement

The Improvement Guide, 2009

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What is Quality Improvement?



Quality Improvement is the combined and unceasing efforts of **everyone** (incl. healthcare professionals, patients and families) to make changes that will lead to:

- Better patient outcomes
- Better experiences of care
- Continued development and supported staff

Defining Quality Improvement (HSE, 2016) (adapted from Atkinson, 2006) Quality Safety Health Care 2017



Also ...

Quality Improvement: A systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement. (The Health Foundation)

7

What is a Learning Health System?

A learning health systems is defined as a health systems "in which internal data and experience are systematically integrated with external evidence, and that knowledge is put into practice. As a result, patients get higher quality, safer, more efficient care, and healthcare delivery organizations become better places to work".

Watch to find out more @NationalQPS Youtube Channel

8

HE QI vs Audit vs Research

- Audit**– How are we performing currently against a standard?
- Research**– What new knowledge can we discover?
- QI**– How do we improve to bridge that gap

9

HE Domains of Quality HIQA National Standards

10

HE Approaches to Improvement

11

HE Steps to Implementing a QI Project

12

HE Opportunities for Improvement.

13

HE Step 1: Identify the Quality Issue

14

HE Step 2: Understand the Problem

15

HE Leadership for Improvement

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Engaging for Improvement

5% 95%

17

Engaging for Improvement

THE INNOVATION DISTRIBUTION CURVE

INNOVATORS EARLY ADOPTERS EARLY MAJORITY LATE MAJORITY LAGGARDS

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Patient Safety Strategy

Patient Safety Improvement Priorities:

- Reducing Healthcare-Associated Infection and Antimicrobial Resistance
- Reducing Medication-Related Harms
- Prevention and Management of Pressure Ulcers
- Reducing and Managing Injury
- Investigation and Response to Clinically Challenging Patients
- Suboptimally Vulnerable Patients
- Improving Safety of Medication
- Prevention of Extremity, Neurological and Appraisal
- Improving Safety for those with Chronic and Mental Health Needs
- Reducing the Risk of Falls from Falls
- Ensuring Safe Discharge of Care including Critical Handover
- Reducing the Number of Prescriptions with Issues in Rates

19

Quality Care Metrics

PROCESS FOR NURSING & MIDWIFERY QUALITY CARE-METRICS

Collect Care Metrics Monthly

Analyse Trends & Present Findings

Enter Data Electronically

Run and Print Reports

Devise Improvement Action Plans

Work with staff to implement changes and meet standards

FRAMING FOR NURSING & MIDWIFERY QUALITY CARE-METRICS

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Mental Health and Disability services

https://www.youtube.com/watch?v=q4u0_0IGLQ

Charting Impact: Unveiling Clinical Audit in Mental Health and Intellectual Disabilities Services, HSE South West.

National Centre for Patient Safety
Launched on 20 So I'm delighted to be here presenting today with colleagues

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Successful Audit and QI Project

Delirium Identification and Management in the Emergency Department (CAAW week 2025 presentation)

Project	Delirium Identification and Management in the Emergency Department (CAAW week 2025 presentation)
Location	University Hospital Kerry
Aim	The aim of this audit to assess compliance with the ED delirium pathway in UHK that involves 24 hour screening for a delirium in all patients >65 years.
Details	<ul style="list-style-type: none"> The 4AT screening tool in triage or at first contact is gold standard practice in the care of the older person. In December 2023 4AT screening on every patient over 65 years was commenced in UHK as part of an ED delirium pathway. Retrospective audit of medical and nursing notes on all patients presenting to the ED over a 30 hour period. Of the 34 notes reviewed only 5 (14.7%) of the patients had a delirium screen recorded in the ED booklet (1:1 Audit) QI: Following consultation with senior nursing staff, the referral process to inpatient bed management was revised to include a mandatory 4AT score as a prerequisite for bed allocation. Changes to documentation supported this. Re-audit showed an increase from 14.7% compliance with delirium screening to 90.91% following a change in processes.
Learning included:	<ul style="list-style-type: none"> Requiring nurses to report the 4AT score to bed management as a condition for admission integrated the screening task into existing workflow, reducing reliance on memory and increasing accountability. This system level change leveraged human factors principles by embedding a cognitive prompt at a key decision making juncture, thereby supporting task completion and improving compliance, sustaining the QI.

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Successful QI Projects

Project	Improving Clinical Handover
Location	Cavan General Hospital
Aim	To investigate and improve the quality of clinical handover within the department of Obstetrics & Gynaecology at Cavan General Hospital using the plan, do, study, Act (PDSA) cycle.
Details	<ul style="list-style-type: none"> Investigated the current clinical handover practice within the department of Obstetrics & Gynaecology. Explored tests of change to improve the quality of clinical handover, in order to meet the best practice standards for clinical handover as laid out by the HSE. Implemented a clinical handover amongst NCHDs, in order to be able to trace accountability. Used the clinical handover model to create a toolkit from this project that can be applied to other handovers within other specialities, and across both acute sites within the RCSI hospital group.
Learning included:	<ul style="list-style-type: none"> Consensus that normal clinical handover face-to-face meetings are maintained, supporting best practice guidance that verbal handover should not be replaced, only supported, by organised systems. Greater mutual appreciation and understanding of roles of manager and clinician Difficult to bring about behavioural change in a large organisation

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Successful QI Projects

Project	Reducing DNAs in surgical and urology outpatient (OPD) appointments; a quality improvement project (2023)
Location	Portlucula University Hospital, Ballinasloe
Aim	Reduce general surgery and urology OPD DNA rates, which were 11.1% (general surgery) and 21.5% (urology) in August 2022.
Details	<p>Four change strategies adopted to reduce DNA:</p> <ul style="list-style-type: none"> Standardised scheduling timeslots; Issued reminder letters 2 weeks prior to appointments; and Offered patient's choice in appointment date if unable to attend.
Learning included:	<p>In general surgery, the OPD DNA rate decreased from 11.1% to 6.3% in the first 2 weeks of the study. Urology OPD DNA rate reduced from 21.5% to 7.4% in the first 2 weeks of the study. These represent promising provisional results, demonstrating significant reduction in OPD DNA rates with easy-to-implement interventions.</p>

O'Donnell O, Dowling C, Garvin J. Practical and easy-to-implement steps to effectively reduce patients who do not attend (DNA) surgical outpatient appointments; a quality improvement project from Portlucula University Hospital, Ballinasloe. Mesenteric Peritonum 2023;7:AB016.

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Successful QI Projects

Project	Do our Cardio Rehabilitation patients achieve healthy Blood Pressure?
Location	HSE Kerry Chronic Disease Hub- Cardiology
Aim	To ensure BP (an important risk factor) is monitored during the patients' journey through cardiac rehabilitation.
Details	<ul style="list-style-type: none"> Cardiovascular disease is the cause of 25.5% of all deaths in Ireland. People with established cardiovascular disease, are strongly encouraged to attend cardiac rehab (CR), as attendance has consistently demonstrated reduced morbidity, hospitalisations and mortality while also increasing quality of life. The 2024 European Society of Cardiology Guidelines define hypertension as office systolic BP of ≥ 140 mmHg or diastolic BP of ≥ 90 mmHg. This was a retrospective study and included all 27 patients who completed the Kerry CDH CR programme from January to June 2024. An excel formula was used to calculate how many patients had systolic BP >140mmHg at pre-assessment and post-assessment respectively. The results of this audit inspired further reflection regarding the accuracy of BP recording in a clinic setting. It is acknowledged that BP readings in clinic setting may not accurately reflect a person's true BP, due to many factors including "White Coat Syndrome". QI: Future patients with elevated in-clinic BP readings asked to complete a Home BP recording sheet, following ESS guidelines for same. When a week of Home BP recordings are completed, the CR team will act accordingly, consulting with the patients GP or Cardiologist if needed.
Learning included:	The human factors involved in this audit include the patients, particularly those who have white coat syndrome, in the context of the second human factor of the clinical setting. This was addressed by educating the patients and teaching them how to record their own BP their home environment.


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Key Success Factors QI Projects

1. Frontline staff Initiative and Engagement
2. Multidisciplinary Collaboration
3. Education and Communication
4. Clear, Measurable Goals
5. Sustainability and Monitoring
6. Data-Driven Interventions

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Leadership for Improvement



The only impossible journey is the one you never begin.

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Annual Prospectus of QPS Education and Learning Programmes



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Interested in this and other QI resources? Contact qps@hse.ie

QI Education Programmes

Step 1 Introduction to Quality Improvement Working as a Team for Improvement ~30 min self-directed learning module on HSELAND	Step 2 Foundation in Quality Improvement ~150 min self-directed learning module on HSELAND	NEW Quality Coach Development Programme 7 modules delivered virtually with coaching circles and mentoring + TTT programme	Step 4 In-depth QI programmes with the RCPI (funded by NGF ID) RCPI PG Cert in QI Leadership S.A.F.E. Programme Embedding QI in Critical Care Outreach STEMi Collaborative
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New! Quality Improvement Guide & Toolkit



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NEW Quality Improvement Resources




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Access the New Pressure Ulcers and Lower Limb Ulcers Clinical Resource Packs



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Patient Safety Together | <https://www.nqpsd.ie> | @NationalQPS | #QIreland

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QUICK Patient Safety Mobile App

An engaging app for healthcare professionals, bringing you on an interactive pathway of learning & activities using clinical care bundles, QI methods and case studies. You can use it on a phone or desktop.

The first two patient safety areas addressed through the app are:

- > Reducing the risk harm from falls
- > Reducing the rate of acquired pressure ulcers.

We are testing the app with pilot participants in hospitals, community services and hospice services.

Scan a QR code below

GET IT ON Google Play

Download on the App Store

Access content On a Computer

SCAN

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Apply to join the Q Community

Q is a vibrant community of almost 6,000 people across the UK and Ireland, collaborating to improve the safety and quality of health and care. And membership is free!



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“Being a member of the Q Community has not only given me access to learning opportunities and a wealth of resources that I can use in my own practice, it has also given me a great opportunity to share my own experiences and expertise with other professionals in the community. It's a real privilege and pleasure to be part of it.”

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Listen to the Walk & Talk Improvement Podcast

Improve patient care by capturing the personal stories of people who work in and use health services.



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Also available on Spotify, Amazon, Google, YouTube



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National Quality and Patient Safety Resources



QPS Competency Navigator

QPS Talk Time webinars

Walk and Talk Improvement Podcast

Patient Safety Together

Learn more about clinical audit

Learn about the Patient Safety Act, Open Dashboards, Just Culture or Incident Management

Use this QR Code to join our meeting list

To access these and all our resources see www.nqa.ie/resources

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Callócht Náisiúnta agus Sabhalteacht Othar
Office of the Chief Executive
National Quality and Patient Safety

NOCA 2026 Conference:

Date & Venue: February 10 @ 09:30am RCSI, Dublin 2

Link to conference page:
<https://www.noca.ie/news-events/noca-annual-conference-2026/>

Call for Abstracts:

- The deadline for the submission of abstracts is 12pm on Wednesday 14th January 2026. Evaluation Committee's decision will be communicated by 5pm on Friday 16th January 2026.
- If you have any questions regarding the conference or abstract submission, please contact audinfo@noca.ie
- Abstracts should showcase how data have been used to: identify opportunities for improvement/test and implement change / embed learning into everyday practice /improve outcomes, experience, safety or equity of care.

MS Forms Application Link: [CLICK HERE](#)

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Callócht Náisiúnta agus Sabhalteacht Othar
Office of the Chief Executive
National Quality and Patient Safety

ISQUA Conference:

Date & Venue: 27th – 30th September 2026, at the Convention Centre Dublin

Link to conference page:
<https://isqua.org/events/dublin-2026.html>

Call for Abstracts:

- The Call for Papers will officially open on 12th November 2025 and close on February 4th 2026.
- The theme for this years conference is "Thriving Through Compassion and Community: Sharing Stories for the Future of Health Systems".
- The links below for the various different sessions take you to the guidelines page and abstract submission page.

Short Oral Lightning Talk and Poster Display: <ul style="list-style-type: none"> Submission Guidelines Submit your Abstract 	Long Session (45+ Minutes) Submission: <ul style="list-style-type: none"> Submission Guidelines Submit your Abstract
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And finally...



Every Accomplishment Starts With the Decision to **Try.**

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The PDF of presentation slides is accessible through the Safety Themes webpage: <https://www.ul.ie/media/60718/download>

The seminar's page on Safety Themes webpage can be found here:



Speech 7

Patient Safety, Pragmatism and General Practice

Dr John Brennan, GP Principal, Gowran Medical Centre;
Adjunct Clinical Lecturer/Assistant Professor, University
College Dublin

The first thing I wanted to say was just, you know, a very big thanks to uh, Anna and to Jill and Sinead, um, EQUIPS and UL for hosting us for this event.

Uh, I think it's great to be gathered here today to look at an area, I suppose, that doesn't get as much attention as it might, given that 90% of all healthcare is happening in the community, right? Um, so I really think it's great that we've had a spotlight, Shannon, today. Um, can I have hands up as well?

Any locals who's from Limerick or based here in the university? Thank you all as well for hosting us so well. Hands up if you're working in general practice as a GP or practice nurse.

OK, hands up if you have a GP. Great. So listen, that is a health, that is a healthcare experience that I'm glad that you all have in in the context of this presentation and it's an experience that I want you to reflect on.

Uh, as we work through the talk, 'cause you are that patient or that person who's navigating the service. And as Jill said, I'm a GP, uh, that's what I do most of the time. Um, and I work in East Kilkenny, uh, with my wife. So, we started general practice there, took over a vacant list.

Uh, in a village, we work across two villages. Uh, in November 2022, we look after about 2 1/2 thousand people, Uh across 265 square kilometres. We've few people who come in and in and out of that area, but that's roughly kind of the area we work. We work within about 1100 of those.

Patients are GMS or doctor visit card patients where they access our services, you know, based on state funding and the rest are private. We employ or the practice employs 7 people, two practice nurses, three members in our in our admin team. And Marie, my wife and I, and we worked very hard to provide, you know, as comprehensive a primary care service as we can. So, you know, we offer things like minor surgery, an extensive kind of Women's Health program, a dermoscopy, a joint injection and whole host of other stuff, right?

Um, but um, you know, before 2022, um, I had this period of time between 2017 and I finished my GP training in 2022 where I worked across lots of different general practices, uh, for different amounts of time. So sometimes maybe just covering for 1/2 a day or a day. Sometimes they're covering.

Covering for maybe 6 or 12 months or whatever, and gained quite a lot of experience and insight into just how heterogeneous general practice is. So, this place where all of this clinical care is happening and how different practices and practitioners think about quality and safety more generally.

What's the best button here for me to press?

And so I mean that question of activity and what's happening in general practice, these numbers are from 2020. So, in 2020 there were 29 million consultations in in general practice in Ireland, right. And we heard earlier from Roisin, you know the proportion of those are nurse delivered or nurse led they were delivered.

And delivered by kind of just under 3 1/2 thousand GPs and their practice teams and their practice nurses. And the literature would tell us that the satisfaction rate with general practice generally is at about 90% and about 90% of the issues that present to general practice are dealt with there and go nowhere else, right? There's no. Kind of other clinician involvement. There's no onward referral or whatever. The average consultation length is about 13 1/2 minutes and the average person visits their GP just over 4 a year.

And in all of that, GPs are not just working to try to keep people safe or to avoid avoidable harm, but they're also at the same time trying to offer care that's timely, available not just when it's wanted, but also crucially, when it's needed care that's effective. So that's.

Based on best practice, the right care for the right patient at the right time, first time, every time with clinical evidence where that's available, it has to be care that's efficient, right? There's a lot of people who need access. We need to reduce as much waste as we can in the system and maximize the.

Value of the interactions that we have with people, um, it's care that's equitable. And again, general practice I would say is 1 setting where the public and private piece works very well in terms of how people access care with no priority, with no priority given.

It's also a place where, um, you know, people are generally looked after regardless of, uh, you know, race or language or creed or whatever else. Um, it's care that's sort of intensely person centred, right? And I think people working in general practice and community care more generally have been thinking about person.

Centre.

This very intensely for a very long time, even longer I would say than maybe people working in other parts of the healthcare system and increasingly GPs and their teams as well are working to try to make the care that they provide as sustainable as possible in their prescribing, in their practice premises, in how they use, um, you know, IT over paper and.

That sort of thing. So I mean the, the key message that I want you to get from this is that yes, keeping people safe is part of what GPs are trying to do, but they're trying

to do that at the same time as, you know, running an organization and providing care that hits all of these other marks as well.

The other thing I suppose to point out is that general practice is a primary care piece of what happens in the community more generally, right? So not all care that's happening in the community is primary care necessarily, but general practice very is definitely primary care and it's often the first place and the first stop for lots of different healthcare.

Problems. So, we have a number of different C's as well that help us achieve those seven kind of quality aims, right? Uh, these six C's as well. So we need to consider ourselves and work to be people's first contact and to make sure that that contact is open.

Whether that's someone walking through the door to a reception desk, calling us on the phone, contacting us through the website, contacting us by e-mail or whatever. And we want care that's not just people centred, but also community centred, right? And again, that's something, uh, you know, that we work, that we work very hard on this.

Idea that a general practice is a community resource. And one thing that we haven't touched a huge amount on today, for example, is, you know, I suppose, people safety in general practice, not just patients, but also the people providing care. And we will unfortunately sometimes encounter incivility, you know, in general practice. Where we might have someone who gets very angry or upset because they don't have what they need when they need us or whatever else. And when that happens within a practice, obviously it can have a very unsettling effect. One of our responsibilities as GPs obviously and employers is for the safety of the people who work with us.

Um. And in that sense, uh, you know, often when we're chatting to these people who've maybe come in quite irate or angry about what's happened, um, we will sometimes highlight to them that the effect that that has on the safety of other people in the building, not just the people that they've spoken to, but also the patients maybe whose care or safety is compromised by the fact that that.

Person at the reception desk was distracted or that doctor was distracted by that interaction or whatever. So, you know, again, we're thinking about community centeredness, we're thinking about general practice as a community and we're thinking about people safety more generally. And as I said, we try to be as comprehensive as we can to deliver as much as we can as close to where.

You know, people live as we can without needing them to go to go elsewhere. We are constantly trying to coordinate services and we've had a good discussion today around integrated care and what that means. But general practice has a huge role to play in terms of tying all of the different pieces back together, putting the people back together when the different knowledge.

To have taken parts of them or diseases or illnesses or particular tests or whatever, trying to put all that back together again to figure out what matters most for someone on a health, on a healthcare journey. We work on continuity and I'm going to talk about that in a little bit more detail in a minute and then as we said, we need. To be accessible, not just in terms of availability, but also in terms of affordability for whatever, you know, 55% or 50% of the population or whatever who are paying out of pocket for primary care services, the big patient safety challenges. I'm not going to dwell on these for long because a lot of them have come up already.

Prescribing and medicines management, as we've seen from the first talk today, is a huge patient safety issue in primary care. More generally, general practice does more prescribing than any of the rest of the healthcare system and has a huge role to play in making medicines management safer and in working with patients to do that, Lorraine mentioned.

Uh, you know, diagnostic safety, safety and safety around kind of diagnostics more generally, all of the different steps involved in, you know, selecting what test needs to be ordered, you know, taking and sending that test, making sure it gets processed in the right place that a result comes back that it's acted on and communication to the person or the patient.

And communication and handover, we're going to come back to again in a minute out of hours and unscheduled care in general practice. And that question came up I think in the chat about a seven day service and how that works. But we know that unscheduled care out of hours care in general practice tends to be at riskier with more patient safety events or incidents happening there and then.

And also there's this challenge around, you know, the environment of general practice. As a lot of you know, a lot of buildings out of which general practice happens are not purpose built necessarily for healthcare. And there are big challenges there. I want to tell you 3 very already.

OK, 33 very brief systems, systems stories that I think kind of illustrate a lot of the themes that we've had today, right? Eileen is a 73 year old Uh woman now in 2026. When we first met her in 2023, she was 70 years old with a history of ischemic heart disease, asthma, Uh, diabetes, depression.

Hypertension, high blood pressure and recurrent ulcers on her legs. And when we first met her, the main issue were these ulcers. Our public health nurse had asked her to come and see her because the ulcers just weren't getting better. When we had a look at what was going on, we could see that she'd been started by a locum doctor at one point on a water tablet for swollen legs.

Without a clear kind of diagnosis as to why those legs might be swollen, she was also on a medication called amlodipine for blood pressure. That's a medication that causes leg swelling. So, we had a situation where someone was on a medication causing a side effect, another medication to treat that side effect. We clarified, I

suppose, that she did not have any, uh, you know, heart failure or whatever and that the leg swelling.

Swelling was probably to do with this medication. We stopped both those medications, got her referred over to the wound management clinic and got her set up for compression bandaging on her legs and we had two years ulcer free, good blood pressure control and feeling well right before Christmas. Then she had a slip. And a fall. She was outside on the ground for a period of time. She was taken by an ambulance crew to the hospital. She was looked after very well there in the hospital and was discharged to the local integrated care service for older people to look at this fall's problem or this fall's risk.

She was met there by a very well meaning clinician who checked her blood pressure. It was very high and they restarted that blood pressure medication that we had stopped three years before. She's back in with me then 2 1/2 or well last week having been seen there 2 1/2 weeks ago, having been on the medication for 2 1/2 weeks. She's feeling very light headed and also, she's got a bit of skin breakdown on her legs again, right? And that's the first kind of system story. We know that her blood pressure goes high anytime a clinician checks it. She has a white coat effect.

And we know that she'd worn a blood pressure monitor six months before and it showed that her blood pressure was very well controlled, right? The second system story is Karen. She's 17. She's one of the 46% of the population that Siobhan told us has private health insurance. She had a sore throat a month ago, just after Christmas, and her health insurer provides free online GP.

GP consultations. So, she contacted the health insurer, got an online consultation. The health insurer found out she had a sore throat or the health, the provider, the clinician on the other end of that video call, took a history, heard about her sore throat or whatever, and prescribed her a course of amoxicillin, penicillin antibiotic for a sore throat.

A week later, the sore throat wasn't better, so she called her health insurer again and got another online consultation. This time with a different online clinician said your sore throat is not better, you probably just need more antibiotics. Another week of amoxicillin. These are video doc consultations. A week later, the sore throat is still not better, so she goes on a weekend. It's.

Walk in doctor in her local town where she pays out of pocket or whatever. They assess her, look into her throat, check her temperature, things like that. Your sore throat is still not better. You need another course of antibiotics and a course of steroids. So, this is the third different doctor. Two video doctor consultations and a walk in doctor.

Doctor, by the time she sees me a week later, her sore throat is not better. She's been on amoxicillin for 21 of the previous 28 days and had a course of steroids, right? We have a look at her, right? We'll take a swab of her throat. We run some

blood tests and we diagnose her as having glandular fever.

Yeah, OK, that's the second system story. The third system story then is tom-tom is 6, right? Last Thursday, he arrived home from school at 3:00. At 3:30. His dad called the practice to say he's got pain in his tummy and he's vomited and he just doesn't look that well. I'm a bit worried about.

Is there any chance we could get him seen? Our receptionist said. Do you know what? We're full, but of course we'll see him, right? So, I saw Tom at half past 5 last Thursday was worried that he might have a testicular torsion, which is relatively rare in a six year old, right? And rather than refer to our.

Local Model 3 hospital referred him straight to our local Model 4 hospital where there would be urology support if needed for a paediatric case like that. He was off the operating theatre table having had things sorted and repaired by 11:30 that night.

That's the third system story, right? So in all of that, very quickly, I want you to recognize that there's a huge amount of complexity, right? This is from a paper we did a couple of years ago where we sat down for kind of up to an hour with 10 different GPs to talk to them about how they were assessing quality of care in their practice, qualitative interviews.

And we found there were 122 different assessment points that they were using. So 122 different factors just amongst those 10 GPs on how they were evaluating the quality of work or informing action in terms of trying to hit those seven domains. Broadly speaking, those 122 factors divided out into GPs.

Professional person factors, patient Co production factors, care team factors, direct care factors, outcome factors, environment and practice environment organization factors, external environmental influences factors and improvement approach factors. I don't have time to talk about it now. Have a look at the paper, OK?

And but again, what we were trying to do is capture this complexity. I think this quota from one of the GPs we interviewed captures it quite nicely. You're not just there to get through the numbers and it is a balancing act. I think it's tricky. You know, you can sit there for 40 minutes talking to every patient. That's not a financially viable model. It's also not a very satisfactory way to work. You know, you want to feel like you, you're being productive.

It's being efficient, getting work done. So again, it's balancing effectiveness. There's efficiency, there's safeness, this person centeredness, this equity, this timeliness, this sustainability. The second point that I want to pull out is around continuity. So, continuity is the superpower that general practice has if we allow it.

To have it when it comes to safety, and there's a big body now of international research from different parts of the world that show good continuity of care reduces morbidity and reduces mortality on aggregate over long periods of time. For people, we have to guard the continuity that we have, we have to protect it, and we have to

design better.

For us, right? We heard from Siobhan earlier about integrated care systems and services. If we don't do that well with continuity at its core, we're in big trouble when it comes to some of the safety stuff that we're already doing really well on. OK, couple of points on that.

Integration, I think is what systems designers and architects do. Continuity and coordination is what a patient and a clinician feel. Yeah, when they're working together on health. And I think we just need to flip things a little bit so that we are seeing and hearing that more in the design of what our future healthcare system is going to be going to look like.

And the second point I want to make is that I want to start a campaign to abandon the word discharge completely. Outside of a clinical context, discharge is what comes from a wound or an infection, right? But it is not what we do to people and their care we hand.

That care over, right? And until we adopt that mindset, there are still going to be chasms of safety when it comes to transitions of care, as the terms we used earlier. I love this slide from Doug EB inside Central Foundation in Alaska, because it shows who's really in control when it comes to health.

In healthcare, yeah, over on the right hand side, when the acuity is very high and you're in an intensive care unit, the system, the healthcare system is managing your care over on this side where the acuity is low and you're out there living your life, accessing or not accessing primary care services as you need.

You are in control, right? And again, when it comes to making people safe in the community, this is what we need to realize. Yeah, we cannot protocolize our way through this. We have to partner.

We don't have a choice because we're not really in control. Um, OK. And the last thing then that I want to show you was around reliability. So in our practice, I think these five principles from high reliability organizations and Lorraine spoke about those earlier have been our most important kind of.

Guiding, guiding, uh, sort of sort of set of principles. So having a preoccupation with failure, recognising there are threats to safety everywhere. Yeah, looking for those, hunting them down and trying to figure them out. That's number one. Number two, a sensitivity to operations. So in our practice every day, we are lucky to be in one of those small.

Practice teams that you know Roshi mentioned earlier as having good strong safety culture. We are aware if you know Lauren's kids didn't sleep last night, she's a bit tired today. We are aware that you know there was a really angry patient on the phone on the phone to Valerie earlier and you know that's been difficult for her or whatever. We are aware of all of that all of the time, how that might.

Impact our team and the safety of the care that we provide and we work around that

deference expertise recognizing that you know Lisa and our practice nurses are the experts in practice nursing. Valerie, Linda, Siobhan are the experts on you know what's happening at the reception desk and in administration.

And then, um, Marie, my wonderful wife, she's CEO, COO, Head of HR, Chief Financial Officer, Chief Strategy Officer, Uh, you know, a mind of legal information, Uh and Chief, you know, Technology Officer, right? Um, so we have to diverse that expertise and use it. Our reluctance to simplify is really important.

Talked about complexity, right, and saying if we just do this, then that'll solve that. Yeah, it's very rare that that works in complex healthcare environments. So embracing complexity and working through that, learning our way through it, the way improvement methods help us to do, as Majella said, and then having a commitment to resilience.

So recognising that the vast majority of the time things are going really, really well, the care people are getting is very, very safe. How do we learn from that? Yeah, the safety too piece that that Lorraine said. And how do we commit to always bouncing back when things don't go to plan?

And another paper I want you to have a look at after, because again, it's within our remit as GPS to, you know, enculture all of these habits for all of our teams, all of the time, including ourselves and reflecting on that. There's a great paper from Bill Lucas from a few years ago.

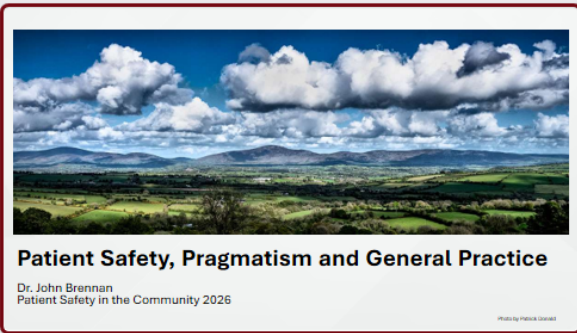
And then just a few very quick closing bits because I know I've gone overtime. I mean for me, pragmatic patient safety in general practice is about embracing and working with complexity, recognising that and the approaches you need to take to work within that. It's about continuity of care, protecting and guarding that no matter, no matter.

What else you do? And then it's working on, I think, reliability, right? And those principles of reliability, what they do is they elevate everyone else up into the severe of kind of responsibility for safety as well. They're my contact details. Lastly, in my remit as a board member with ISQA.

Please check out the conference coming later this year. It will be the kind of key international global quality and safety event this year. Uh, so it's coming to Dublin. It's a great opportunity to be there and to kind of see how a lot of this is working across other parts of the world as well. Closing day for papers is the 4th of February. And here are all the reasons to get involved. Uh. And lastly then, um, you know, a lot of this are, you know, is in some of the books that we've written and published with Oxford University Press. And there's a code at the bottom there if you want to get a discount on any of those. Um, but there is a chapter in the paper.

Patient safety handbook on primary care, lots in the quality improvement handbook as well on what Magella was talking about and different approaches and then bits on

leadership and management as well, OK. Thank you.



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I have no conflicts of interest to declare

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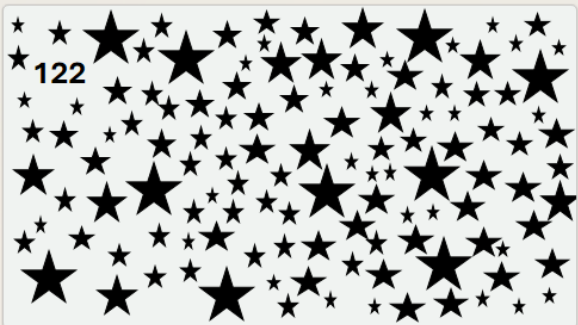
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- What are the big patient safety challenges in GP?**
- Prescribing and medicines management
 - Diagnostics and diagnosis
 - Communication and handover
 - Out of hours and unscheduled care
 - Environment and human factors

6

Three Systems Stories

7



8



9

★

“You’re not there just to get through the numbers and it is a balancing act. I think it’s tricky....you know, you can sit there for 40 minutes talking to every patient. That’s not a financially viable model. It’s also not a very satisfactory way to work. You know, you want to feel like you’re, you know, you’re being productive, being efficient, getting work done.”

Complexity

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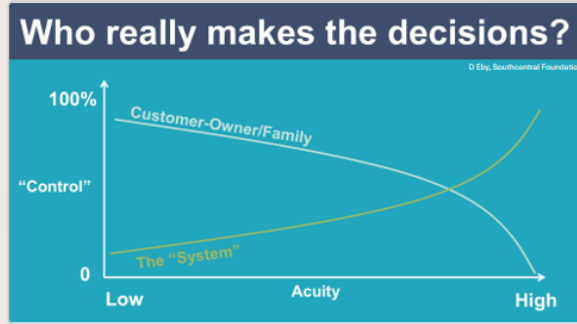
Continuity

Lau RS, Bosaen ME, Richer L, Hill MD. Siloed mentality, health system suboptimization and the healthcare symphony: a Canadian perspective. *Health Res Policy Syst.* 2024 Jul 17;22(1):87.

Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open.* 2018 Jun 28;8(6):e021161.

Sandvik H, Hetlevik Ø, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. *Br J Gen Pract.* 2022 Jan 27;72(715):e84-e90.

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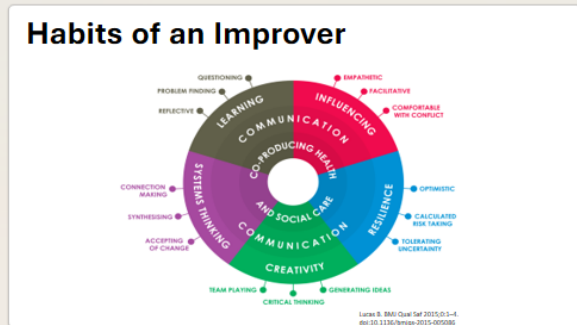
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Reliability

A preoccupation with failure
Sensitivity to operations
Deference to expertise
Reluctance to simplify interpretations of issues or risks
Commitment to resilience

Weick and Sutcliffe, 2007

13



14

Pragmatic Patient Safety in General Practice is.....

- Complex
- Continuous
- Reliable

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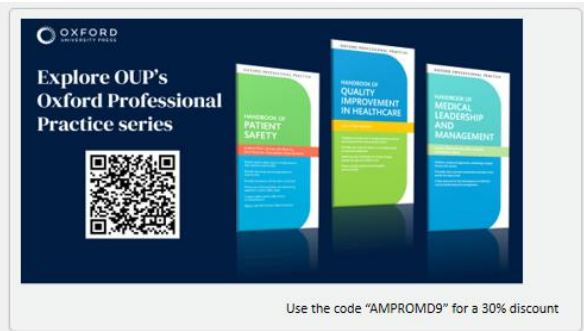


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Summary of event and synthesis

Associate Professor Anna Chatzi, School of Nursing and Midwifery, University of Limerick

Dr Jill Poots, EQUIPS Research Network Manager

JP: Anna, is that a nice starting point for us? I wonder to synthesise everything we've heard. What actions or what challenges do we need to work on?

AC: Yes, Jill, a lot of strong themes that came today from today's presentations and one of them was communication was the one of the most strong ones, right. So, communication breakdowns were the ones that were, you know, discussed today. Medication risks, more specific.

Specifics for patients and they appear mostly with people when people take their medicines or when they take high risk drugs. But we even discussed about paracetamol, right? Something that is available over the counter and still people patients experience harm.

Something else that came out was heavy workloads for clinicians, people coming in and out from different dealing with different situation, patient conditions, heavy workloads, unexpected workloads. So that's something that came out and then. Poor coordination between services and continuity of care, as John mentioned earlier, that's something we really need to focus on. And last but not least, what I have in my notes here is weak incident management processes is something that we really need to build on. So, Jill, what have you put in your little notes there for the day?

JP: I think I suppose we're all maybe similarly aligned. I mean some of the like one of the things I said was the biggest surprise is we had all these amazing presentations from all over the healthcare space. But like you said, Anna, we've got so many common threads running through and this communication.

Peace and the non-technical skills piece. I just, I wonder if there's more to do in patient safety with that. We've spoken about, you know, undergraduate medical education and getting it in there. I suppose there's things like simulation. How do you simulate this? You know, is there be a really interesting research and point of view, anything to pick up on what?

John said about these sort of the 17 year old and going through multiple systems. You know, I've seen that in my personal life with people going through their private health care app, through the out of our services, through the GP and getting, you know, the same dose of antibiotics and steroids for I think about 8 weeks in my family member's case.

So I think there are lots of questions that we still haven't really tapped into in the

research space about these sort of multiple providers as well. And maybe that's another a launchpad for further conversations about that. So those would be my takes.

AC: That's excellent. Yeah, actually that was my thought as well because we really need to go. We said it earlier. I think we need to highlight it now that we really need to put ourselves into the patient's shoes and think, consider their journey through the services, how they are navigating that and try to have a design that it's suitable. For them, but they come into the system with no terminology. They don't know how to communicate the very high level language that we're communicating. So, they try, they struggle to understand what we're telling them. We really need to.

So I have experience. I'm a nurse myself and my background, so I have experience. Doctor comes into the room, discusses with patient doctors, goes out of the room, then the patient asks the nurse. What did the doctor say? Yeah, so and you really need to repeat in common terms what happened in the room and what their condition is and what they need.

Need to do. So, I think it's a much very, very complicated problem to solve and make it very simple for patients. So, I really it was really nice to hear about tools that are very helpful to patients like Louisa, the one that Louisa mentioned about.

Patient's medication, everything in one place so that patients are aware of their medication and really know what's what they have in their drawer. So that's a good thing to have tools for them available to them, accessible so that they can keep track of their condition and what they really need to do into their journey.

Open and clear communication. That's something that is learned. People, clinicians should be trained for that, and that's something we have in place, and we need to become better at training, of course, as a means to create good.

Processes, not train and education, as Lorraine said, just for the sake of education and training, it wouldn't work. And we need also to create good coordination among services. That's something that we really need now to focus on and work hard for so that we see no harm.

JP: Happening again to our patients and that's the goal. Yeah. Yeah. And I think that's the benefit of having a kind of an event like this where we can actually talk about this. And so, it's just to echo some of those bold ideas, you know, and all of those tools again. So, I do hope that you all kind of can take something away from today. Whether.

It's a very practical thing to do, like a resource, or whether it's a tool that you haven't heard of. I really like that pyramid, for example, that Lorraine had on from training to design and trying to actually design things out in the first instance rather than just responding to things or learning from excellence and not just asking for help maybe. Maybe when something's gone wrong, but you know, sharing good practice or asking someone, you know what's going well for you this week and that you're really

proud of doing as well in your workplace, if that's relevant. So yeah, lots, lots to do.

AC: But there is a confusion. I mean, still confusion what we got is.

From patients and from clinicians, so from the advocacy service that patients are looking to find their way, they need support, things are not very easy for them. So that's one piece and clinicians, I mean there is this lack in the communication bit. So, clinicians are still afraid to talk about adverse events or near misses. What's happening? They're reluctant to say I'm sorry because they think it comes with litigation and it doesn't. So, communication and being informed is crucial.

To everybody and we really need to make things that we have them. We have the processes, the process that we have in place. We really need to communicate them efficiently to everybody, to all involved and try to make our processes even more, I would say integrated.

In a sense that there is continuity among services, but also simple and easily to be navigated easily by everybody. So yeah, I think that's what I kept.

JP: Yeah. And I think I had a lunchtime or a tea break conversation about health literacy as well in primary and community care and like how big a time.

I suppose that is to support and promote health literacy so everyone understands like what actually is happening when I go into my GP, what are what are they looking at on their computer? If I use an app, who am I speaking to? Like that's come up today and I think that's the great thing about having the patient advocacy service there as well and having those.

Supports in place that patients can get, as Georgina said earlier, a service and some sort of guidance as minimum of as to where to go next. So, see, it's been a big day. Thank you, bye everybody.



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