An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

HSE National Quality and Patient Safety Directorate: How we work with you for patient safety

Lorraine Schwanberg, Assistant National Director Incident Management (NQPSD)

7th October 2022

National Quality & Patient Safety Directorate Purpose

- The National Quality & Patient Safety Directorate (NQPSD) was **established in mid-2021** as a result of the HSE Central Reform Review.
- Across the National Quality & Patient Safety Directorate (NQPSD), we work in partnership with HSE operations, patient representatives and other internal & external partners to improve patient safety and the quality of care by:

Building quality and patient safety capacity and capability in practice

Using data to inform improvements

Developing and monitoring the incident management framework and open disclosure policy and guidance

Providing a platform for sharing and learning

Reducing common causes of harm and enabling safe systems of care and sustainable improvements

NQPSD Organogram

Office of the Chief Clinical Officer

Office of the National Clinical Director Quality & Patient Safety

National Centre for Clinical Audit*
Lead: Assistant National Director

Patient Representatives

- **Patient Safety Programme*** — Lead: Assistant National Director
- **QPS Improvement*** — Lead: Assistant National Director
- **QPS Intelligence** — Clinical Lead: Public Health Specialist
- **QPS Incident Management** — Lead: Assistant National Director
- **QPS Education** — Clinical Lead: Public Health Specialist
- **QPS Connect** — Lead: Director of Nursing

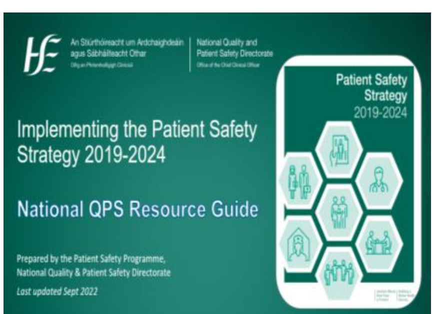
* Patient Safety Programme, QPS Improvement, and NCCA are subject to reconfiguration

National Quality & Patient Safety Directorate

In line with the *Patient Safety Strategy 2019-2024,* the Directorate delivers on its purpose through the following teams:

1. **Patient Safety Programme:** Oversee and monitor the implementation of the HSE Patient Safety Strategy
2. **QPS Improvement:** Use of improvement methodologies to address common causes of harm
3. **QPS Intelligence:** Using data to inform improvements in quality and patient safety
4. **QPS Incident Management**: Incident Management Framework, Open Disclosure Policy & National Incident Management System
5. **QPS Education:** Enabling QPS capacity and capability in practice
6. **QPS Connect:** Communicating, sharing learning, making connections
7. Establishment and operation of the **National Center for Clinical Audit**

Patient Safety Programme



- The role of the Patient Safety Programme is to oversee and monitor implementation of the Strategy, and act as a central hub for implementation information, shared learning and resources.
- The teams within the NQPSD are the means through which the Directorate delivers the Patient Safety Programme.
- Collaborative approach to support local implementation

Our Approach to supporting Implementation of the Patient Safety Strategy

National Quality & Patient Safety Directorate
Tiered Model of Support

Tier	Tier Description	Model of Support	Examples of Support
Local Implementation	Signposting & support packages for local projects which are led through engagement with patients and frontline staff.	We have developed, and continue to develop, a range of QPS tools and resources to support local Patient Safety Strategy implementation and improvement projects across local care pathways.	• QPS Resource Guide and Improvement Toolkit • QPS Prospectus of Education and Learning Programmes • Foundational online training programmes in QI, Clinical Audit, and Human Factors • Library of Webinars & short videos e.g. "Making the most of your Safety Huddle" • Communication aids e.g. posters & infographics
Larger-scale Implementation	Tailored support for larger-scale projects delivered collaboratively within hospitals, hospital groups and/or CHOs.	Customised support to hospitals and/or community services to pursue a wider population approach, addressing specific Commitments of the Patient safety Strategy or Common Cause of Harm in partnership with existing programmes / models of care. Implementation is locally owned and nationally enabled.	• Tailored project clinics & webinars, bringing together subject-matter expertise with tried & tested approaches to QI and QPS • Blended training opportunities (online & face to face): for example, Improvement in Practice Programme, Open Disclosure, Incident Management, Human Factors, and Clinical Audit
Programmatic Implementation	Dedicated partnership with national clinical & integrated care programmes, across Hospital Groups and/or CHOs.	A range of supports to co-design and deliver wide-reaching improvements addressing multiple strategy commitments and actions across Hospital Groups and/or CHOs to mobilise resources and support delivery. Work towards sustainability, spread, and shared learning across the system	• Delivery of accredited postgraduate programmes to targeted clinical teams, building QPS capacity & capability • Coordination of subject-specific Collaboratives and Learning Sets to address highest patient safety priorities • Regular schedule of site visits and meetings to provide coaching and support

Draft – last updated Sept 2022

QPS Incident Management Lead: Lorraine Schwanberg

Lorraine.Schwanberg@hse.ie

QPS Incident Management

- Develop and implement effective, person-centred Incident Management and Open Disclosure Framework/Policies, Processes and Procedures which support staff to practice safely, including identifying and reporting safety incidents and managing and improving patient safety in a positive learning culture.
- Incident Management
- Open Disclosure
- National Incident Management System (NIMS)

QPS Incident Management

Learning

Patient Safety Together:

learning, sharing and improving

A freely available online resource that will enable all users to access and download new and up to date patient safety information.

Purpose

To support staff

- to use its content as a rich resource to identify and apply relevant learning for QPS improvements at all levels
- to engage with incident reporting, facilitating closing the loop on incident reporting and review by supporting sharing of learning

To support patients / service users

- to easily access information on QPS issues that are relevant to the Irish healthcare system and to keep them up to date with the latest information

To reassure anyone involved in a patient safety incident that by identifying and sharing learning we aim to prevent similar incidents recurring

Signposting to other patient safety content will also be included

QPS Conferences

New QPS Research

QPS Data

QPS Resources

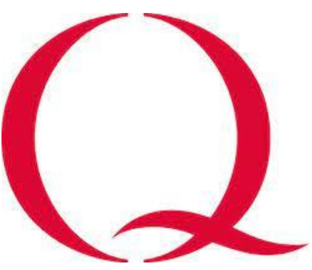
Safety Stories

The aim of Safety Stories is to give a voice to the patients/service users and staff who have been involved or impacted by patient safety incidents. Storytelling has been shown to be effective in creating a dialogue to both increase safety awareness and assist in connecting knowledge to action. Experiences can both be positive or negative and will be worthy of sharing in the interest of learning.

Patient Safety: learning, sharing and improving community

Exploring with a QPS working group how a Special Interest Group (SIG) can support QPS Staff through the Q Community's Platform

How?



- Peer Support
- Sharing of Resources
- Discussion Forum
- Sharing of Learning

Patient Safety Alerts

A **Patient Safety Alert (PSA)** is a high priority communication in relation to patient safety issues, which requires HSE services and HSE funded agencies to take specific action(s) within an identified timeframe, in order to reduce the risk of occurrence or recurrence of patient safety incidents that have the potential to cause harm.

PSAs are issued by the HSE in conjunction with relevant stakeholders (subject matter experts, patient representatives, clinical & academic experts)

HSE National Patient Safety Alert

Date of Issue: 26 Sept 2022
Unique ID: HSENPSA 0001/2022

PRIORITY 2 –Warning

Risk of Harm from Codeine-Containing Products

Who needs to take action on this safety issue?

This HSE National Patient Safety Alert (NPSA) is for action by all Health Service personnel involved in caring for patients suspected to have experienced harm arising from dependence on codeine-containing products, including toxicities associated with the analgesic component of combination products.

What is the safety issue?

Regular or prolonged use of codeine-containing products may produce psychological and physical dependence. For combination products, use of higher doses and/or for a longer duration than that recommended, can also lead to serious adverse clinical outcomes arising from exposure to the analgesic component (e.g. paracetamol or ibuprofen). These include hepatotoxicity, gastrointestinal and renal toxicities, such as gastrointestinal haemorrhage and perforation and renal failure[1].

What action is required?

1. Circulate this NPSA to all clinical staff who provide care for patients who may be impacted by the use of codeine-containing products, particularly in the specialities of Gastroenterology, Nephrology, Gynaecology, General Practice, Pharmacy and Psychiatry and Addiction Services.
2. Staff should report cases of suspected harm (past or current) to the Health Products Regulatory Authority (HPRA) via the HPRA's online adverse reaction report form available at: https://www.hpra.ie/homepage/about-us/report-an-issue/human-adverse-reaction-form or by phone on 01 676 4971.
   - It is not necessary to complete all fields of the online form, however, as much information as is known should be provided. Include the brand name(s) of the suspect medicine(s), or if unknown, state all active ingredient(s) (e.g. ibuprofen codeine combination product). Provide a summary of available information on the circumstances of use (e.g. if use was prescribed and/or accessed over the counter 'OTC', duration and quantity), details of any suspected dependence or misuse, and any associated suspected reactions (i.e. adverse clinical outcomes).

When does the action need to be completed by?

Please circulate this HSENPSA to relevant staff by 21 Oct 2022.

Why is this action required?

The HPRA are the competent authority in Ireland for pharmacovigilance and operate a system through which suspected adverse reactions can be reported by health care professionals. A small number of cases describing significant harm relating to the analgesic component of codeine-containing combination products, in the context of dependency to codeine, have recently been reported to the HPRA via the national adverse reaction reporting system. As the system is voluntary, there may be under-reporting of such cases. The HPRA are therefore encouraging reporting of any similar cases that you may be aware of for pharmacovigilance monitoring purposes.

Page 1 of 2

Dissemination of Patient Safety Alerts

Patient Safety: learning, sharing and improving together

Open Access -

Repository of searchable PSAs

QPS E-Alert System -

PSAs forwarded to 'Designated Persons' in services

Patient Safety Supplement

PATIENT SAFETY SUPPLEMENT

Failure to Recognise Sepsis in the Deteriorating Patient

This *Safety Supplement* shares learning from reviews of cases reported from Irish healthcare settings to the National Incident Management System (NIMS) involving failure to recognise sepsis in the deteriorating patient. It includes a summary of evidence and patient safety strategies for healthcare providers to consider.

CASE EXAMPLE

Ms. E was brought in by ambulance to the Emergency Department (ED) with fast atrial fibrillation and chest pain. Ms. E had a history of a fractured right humerus, Asthma, COPD, NIDDM, Atrial Fibrillation, Hypertension, CCF, and recurrent falls. The patient was seen by the ED Senior House Officer (SHO), and a provisional diagnosis of Angina was made.

Ms. E was admitted but her clinical condition deteriorated over the weekend on days 3 and 4. On day 5 she became unresponsive and hypoxic and subsequently suffered a cardiac and respiratory arrest. Despite intubation and ventilation and treatment in the Intensive Care Unit, Ms. E sadly died. Cause of death was multi-organ failure secondary to septicaemia. On review of the case it was identified that overall escalation protocols were not adhered to consistently by Nursing and Medical Staff

PATIENT STORY (As told by the patient) +/- picture

I had been unwell with vomiting and diarrhoea and had spent a number of days at home in bed. I had bad pains in her legs and on day 3 I fell, due to the severity of the pains. I felt very unwell throughout the day and later that night my husband called an ambulance and was brought to the ED ....

EXPERT COMMENT

EXAMPLE: Sepsis is a common time-dependent medical emergency. It can affect a person of any age, from any social background and can strike irrespective of underlying good health or concurrent medical conditions.

Internationally, approaches to sepsis management care based on early recognition of sepsis with resuscitation and timely referral to critical care have reported reductions in mortality from severe sepsis/septic shock in the order of 20-30%..........

National Clinical Lead Sepsis:

Programme Manager, National Deteriorating Patient Improvement Programme & Sepsis:

OR

Dr A. Smith, Consultant Anaesthetist

Ms. B. Murphy, Programme Lead

DRAFT - MAY NOT BE ACCURATE - FOR TESTING PURPOSES ONLY

A **Patient Safety Supplement** (PSS) informs HSE and HSE funded agencies of timely and relevant quality and patient safety information for learning purposes.

Content will be identified from several patient safety intelligence sources including the analysis of incident reporting, reports from front line services, or new national or international research and evidence.

Fair and Just

Commitment two of the HSE's Patient Safety Strategy sets the ambition for a compassionate, just, fair and open culture and states that "staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in patient safety improvement initiatives".

What is a Just Culture

A values based supportive model of shared accountability (IMF 2020)

Proposes that:

- The main focus of analysis of safety issues is on system failures. These are identified and to the extent possible corrected.
- The organisation accepts appropriate responsibility and accountability. Individual Practitioners should not be held accountable for system failings over which they have no control
- Does not absolve staff of the need to behave responsibly and with professionalism.
- Does not tolerate conscious disregard of clear risks, disregard for the welfare of patients or staff or wilful misconduct and misbehaviour.
- Staff feel psychologically safe both to report errors and to ask for help when faced with an issue beyond their competence

"A collective understanding of where the line should be drawn between blameless and blameworthy actions" (James Reason)

Transparency and Openness

MISSION

Promoting and supporting a culture of honesty and transparency through compassionate and empathic communication with our patients, service users, their families and staff.

VISION

Everyone experiences open, compassionate and timely communication and will be supported when things go wrong, for whatever reason, in our services.

VALUES

Care
Compassion
Trust
Learning
Person Centred
Kindness
Empathy
Openness
Honesty

"The ethos of the National Open Disclosure Policy and Programme is based on ensuring that the rights of all patients (and their relevant persons, as appropriate) to be communicated with in an open, honest, timely and empathic manner following patient safety incidents are met and respected and that they experience dignity, respect and compassion throughout that communication process.

Open Disclosure is the right thing to do and it is important that we do it right".

Open Disclosure

Support in implementation from NODOffice
Open Disclosure LeadsOpen Disclosure Leads in CHOs, Hospital Groups (with site leads in each hospital), NAS, Screening services and Some of the voluntary agencies.
Webinar series and many resources to support staff
Assurance system re compliance and experience

Open Disclosure training is mandatory for all staff.
Module 1 online programme on "Communicating effectively through Open Disclosure"
Module 2 of online programme "Open Disclosure: Applying Principles to Practice"
Advanced, accredited face to face programme to complement online module
Working with Training Bodies re OD on curriculum

HSE Open Disclosure Policy
DoH Open Disclosure National Policy Framework
Civil Liability Amendment Act
Patient Safety (Notifiable Patient Safety Incidents) Bill 2019

National Incident Management System

- National Incident Management System (NIMS)
  - ePOE (direct electronic incident reporting onto the system by the reporter)
  - Data Quality improvement work
  - System development
  - NIMS User engagement

What is ePOE?

Point of entry reporting is where front-line staff enter incidents directly onto NIMS, eliminating the need for paper reporting.

To date, HSE and HSE funded services across Ireland have relied on either a paper based reporting system or secondary software to capture incident data before manually inputting this data onto the National Incident Management System (NIMS).

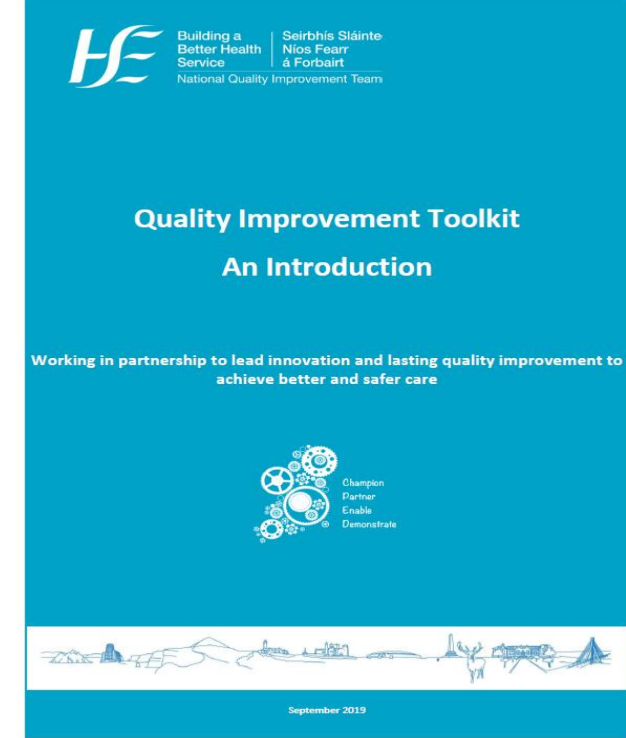
NIMS has the functionality to perform as an end-to-end incident management tool that will allow services to manage incidents through the incident lifecycle on a single platform to improve the quality and safety of care provided. The significant benefit of the national platform is that there is the opportunity for wider system learning.

QPS Improvement Lead: Maria Lordan Dunphy

Maria.LordanDunphy@hse.ie

QPS Improvement

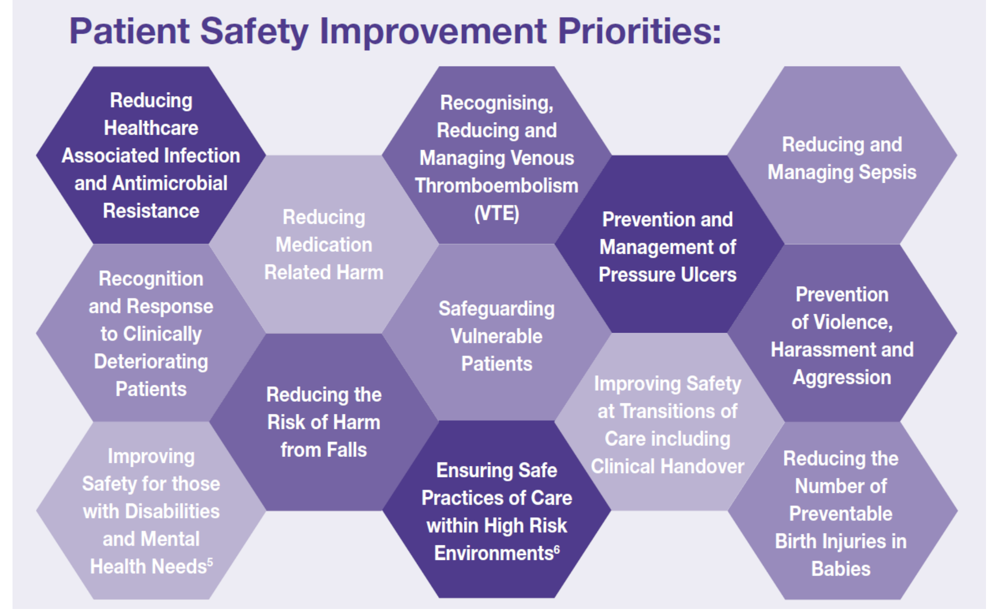
- Currently updating the QI Toolkit
  - Includes 17 practical tools to support completion of Quality Improvement projects.
  - Tools are appropriate for each of the four phases of the project, starting out with a ‘light bulb’ moment right through to the sustainability plan, where you are embedding the improvements you have achieved.



Common Causes of Harm

Linking with Programmes to address Common Causes of Harm

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



QPS Improvement

- Mobile app to support improvements in Pressure Ulcers and Falls Prevention
  - Awarded funding from the Health Foundation in Q3 2022
- National Wound Care Improvement Programme to commence shortly
- Previous work undertaken:
  - Falls Collaborative
  - Pressure Ulcers to Zero (PUTZ) Collaborative

Medication Safety Programme ("Safermeds")

- Priority action areas
  - Transitions of Care
  - High Risk Situations/Medication
  - Polypharmacy (inappropriate)
- Public information and messaging, including the Know Check Ask campaign and the HSE's Medicines A-Z.
- Rollout of HSE PCERS portal in collaboration with the Office of the CIO, PCERS and hospitals, to make dispensed medication information available to hospital pharmacists via a web based portal to facilitate medication reconciliation at admission for hospital pharmacists to 20 hospitals.
- iSIMPATHY
  - EU funded project in Northern Ireland, Scotland and the Republic of Ireland.
  - ensure the best and most sustainable use of medicines for patients by training pharmacists and other medical professionals to deliver medicine reviews and embedding a shared approach to managing multiple medicines.
  - Indicators show benefits in patient safety, quality and appropriateness of prescribing with a return of investment in excess of spend.

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QPS Intelligence Lead: Dr Jennifer Martin

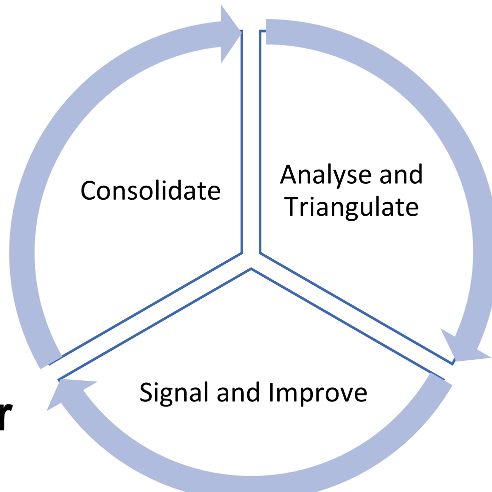
jennifer.martin@hse.ie

QPS Intelligence Team purpose is to
Use data to inform improvements in quality and patient safety
and Support others to do the same!

Quality and Safety Signals Project

- **Design & implement a quality and safety surveillance system which optimises the use of existing data to reduce variability in quality and safety of services, identifies risk and signals of concern as well as learnings from signals of excellence**
- **Scoping and stakeholder engagement in 2022, design and development about to start!**

Project Timeline



If you are interested in getting involved in hearing more or getting involved in this project, contact QPSI@hse.ie

QPS Research

Rapid Response Research	• Study on the clinical impact of the cyber-attack **https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-reports/cyber-study-report.pdf** • CAHMS family experience research
Commissioning of Research and Evaluations	• Research on QPS competency framework, QPS health economics competencies, QPS composite safety signals, Learning from incidents • Schwartz Rounds evaluation https://www.hse.ie/eng/about/who/nqpsd/qps-connect/schwartz-rounds/full-trinity-report-may-19.pdf
Research Awards	• Migrant women and ethnic minority group's experiences of maternity services (DOH Women's Health Fund) • PhD scholarship on Measurement for Improvement knowledge and skills among healthcare staff
Collaboration as Knowledge Users	• After Action Reviews (HRB APA) • Medication safety (RCQPS & HRB) • Staff experience during Covid (HRB/IRC & Q Community)

‘Measurement for Improvement’ support available to clinical programmes

Measurement for Improvement Guidance, Tools and Templates available online
https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/measurement-for-improvement-resources.html

Provide 1-1 Measurement for Improvement advice on your measurement plan and analysis.

Contact QPSI@hse.ie

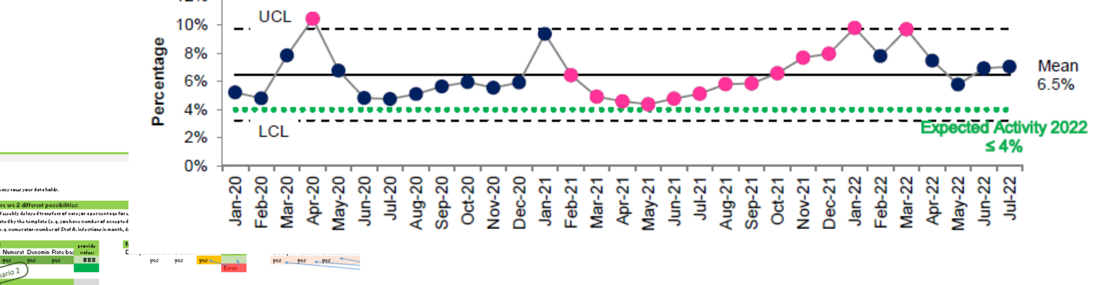
Template for Statistical Process Control (SPC) graphs

- User friendly template available in Excel for 8 graphs

My Chart: U Funnel

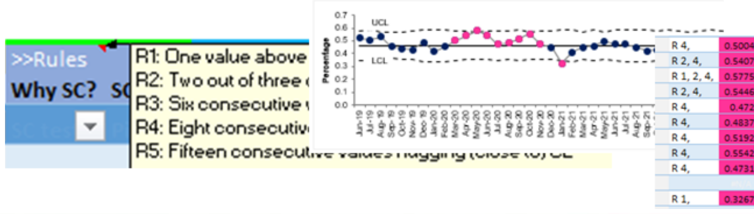
- P Chart
- P Prime Chart
- U Chart
- C Chart
- I Chart
- P Funnel
- P Prime Funnel
- U Funnel

- Calculates the graph and displays special cause applying the rules and visualisations developed for HSE reports. These are currently used in the Quality Profile produced for the Q&S Board Committee and included in the NPOG brief.



- Template calculations are automated. User only needs to copy-paste data and select type of graph. Intro page and demo videos available as support materials. Coming soon also information on SPC recommended applications and benefits.

- Highlights the rules applied and rationale for special cause variation points



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QPS Education:

'Supporting a culture of continuous learning by enabling the development of QPS competence across our health system'

Lead: Dr Mary Browne

Prospectus of Education & Learning Programmes

Includes information about our learning programmes and networking opportunities covering topics such as;

- Incident Management
- Open Disclosure
- Quality & Patient Safety Improvement
- Clinical Audit
- Human Factors
- Schwartz Rounds
- QPS Connections and Networking Opportunities

- Access at https://www.hse.ie/eng/about/who/nqpsd/qps-education/education-learning-programmes-and-resources.html

Quality Improvement Programmes of Learning

QI Leadership

42 week academic blended learning delivered in partnership with RCPI – QQI Level 9 72 CPD

Improvement in Practice

20 week blended learning (40 hours min)

7 x 2 hours SDL
7 x 3 hours classroom
5 x 1 hour clinic
Additional reading/resources

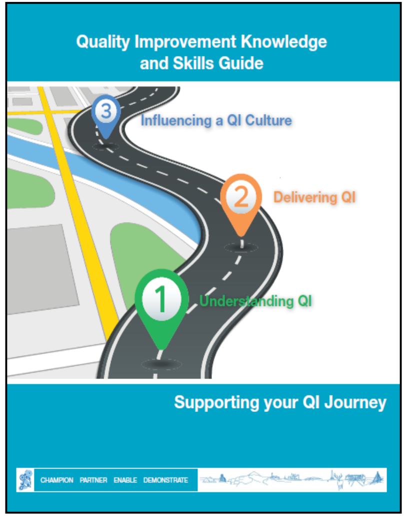
Foundation in Quality Improvement

3 hours e-learning

Introduction to Quality Improvement

30 min e-learning

Additional QI learning resources available



QI Knowledge and Skills Guide Assessment

Available on our website:

https://www.hse.ie/eng/about/who/nqpsd/qps-education/knowledge-and-skills-guide.html

QI Terms and Concepts used in the Irish Healthcare Setting

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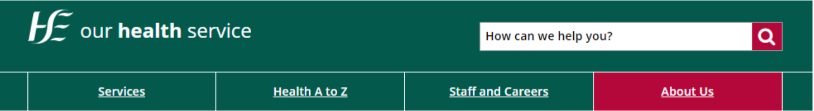
QPS Connect Lead: Dr Maureen Flynn

Our Front Door: Website

Interim



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- **National Quality and Patient Safety Directorate**

National Quality and Patient Safety Directorate

As the National Clinical Director of the Quality and Patient Safety Directorate (NQPSD), I welcome you to explore our webpages and learn more about the role of the NQPSD within the HSE. The work of the NQPSD is anchored in the HSE Patient Safety Strategy 2019-2024. The NQPSD teams look forward to collaborating and supporting you in delivering quality and patient safety service improvements.

Dr Orla Healy, National Clinical Director, Quality and Patient Safety

CLICK HERE for National QPS Directorate events and awareness campaigns to mark World Patient Safety Day, 17 Sept 2022

Purpose

The National Quality and Patient Safety Directorate (NQPSD) works in partnership with HSE operations, patient partners and other internal and external partners to improve patient safety and the quality of care by:

- building quality and patient safety capacity and capability in practice
- using data to inform improvements
- developing and monitoring the incident management framework and open disclosure policy and guidance
- providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Teams

In line with the Patient Safety Strategy 2019-2024, the Directorate delivers on its purpose through the following teams:

- QPS Improvement: Use of improvement methodologies to address common causes of harm.
- QPS Intelligence: Using data to inform improvements in quality and patient safety.
- QPS Incident Management: Incident Management Framework, Open Disclosure Policy and National Incident Management System. Working with stakeholders to identify, develop and share patient safety learning
- QPS Education: Enabling QPS capacity and capability in practice.
- QPS Connect: Communicating, sharing learning, making connections.
- Establishment and operation of the National Center for Clinical Audit
- National Independent Review Panel (NIRP)

Join us for QPS TalkTime

Twice monthly Tuesday lunch time webinars

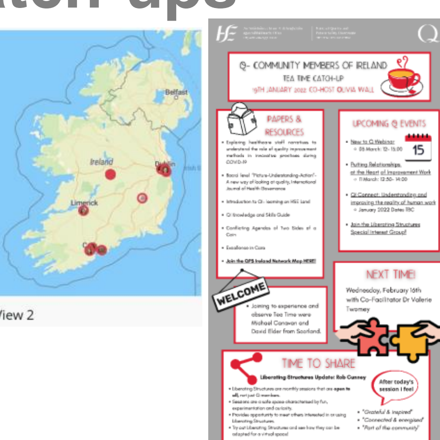
Listen to our podcast!

Connect through

Opt into: QPS Ireland Network Map, Q-Community, monthly T-team catch-ups

View 1

View 2



Follow and tag us on twitter

@NationalQPS
@QPSTalkTime
@NCCA

#QIreland
#patientsafety

HSE National Centre for Clinical Audit

Background - National Clinical Audit

National Review of Clinical Audit 2019 was commissioned by Dr. Colm Henry, CCO

The Review Report contained **25 recommendations** (circa 80 actions)

https://www.hse.ie/eng/services/publications/national-review-of-clinical-audit-report-2019.pdf

Key Findings of the National Review of Clinical Audit Report 2019

- Absence of National Clinical Audit Governance structure
- Opportunity to improve collaboration between all clinical audit stakeholders/service providers
- Limited support for local clinical audit e.g; guidance, tools, resources and training

HSE National Centre for Clinical Audit - 5 Key Pillars

National Governance for Clinical Audit

Local Governance for Clinical Audit

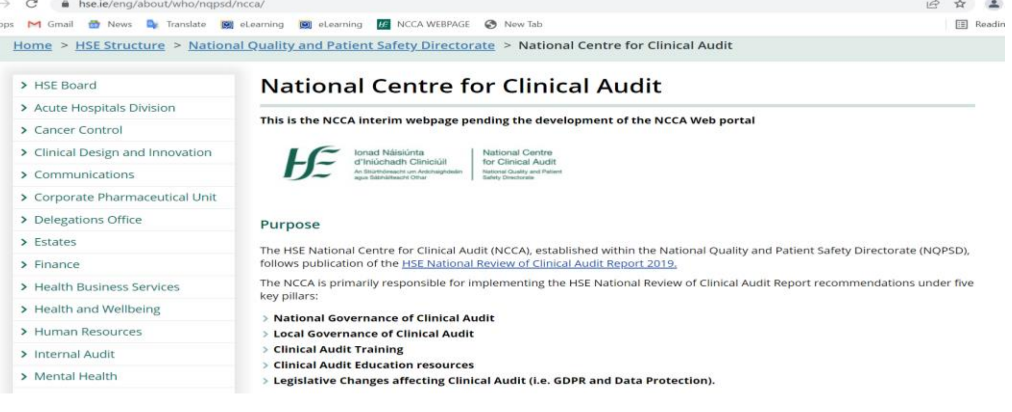
Clinical Audit Education and Training

Clinical Audit Education and Resources

Legislative Changes

National Centre for Clinical Audit

www.hse.ie/eng/about/who/nqpsd/ncca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- Estates
- Finance
- Health Business Services
- Health and Wellbeing
- Human Resources
- Internal Audit
- Mental Health

National Centre for Clinical Audit

This is the NCCA interim webpage pending the development of the NCCA Web portal

Purpose

The HSE National Centre for Clinical Audit (NCCA), established within the National Quality and Patient Safety Directorate (NQPSD), follows publication of the HSE National Review of Clinical Audit Report 2019.

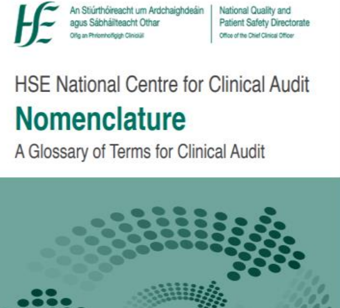
The NCCA is primarily responsible for implementing the HSE National Review of Clinical Audit Report recommendations under five key pillars:

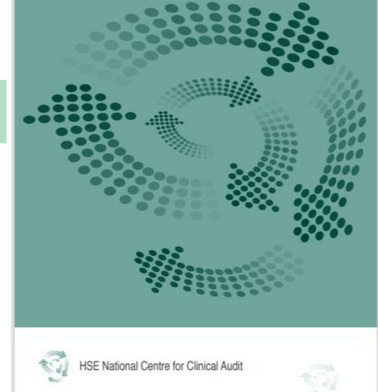
- **National Governance of Clinical Audit**
- **Local Governance of Clinical Audit**
- **Clinical Audit Training**
- **Clinical Audit Education resources**
- **Legislative Changes affecting Clinical Audit (i.e. GDPR and Data Protection).**

HSE National Centre for Clinical Audit Training Programme 2022

In partnership with Clinical Audit Support Centre (CASC)

HSE National Centre for Clinical Audit





Range of Clinical Audit Training programmes commenced May 2022

Training Dates 2022
Clinical Audit Training Programme

Fundamentals in Clinical Audit Course

Session 1 (one full day)	Workshop session 2 (one half-day)
17 May	25 May (am and pm sessions available)
18 May	
27 September	14 October (am and pm sessions available)
7 December	

Advanced Course	Train the Trainer in Clinical Audit
One day	One day
10 June	24 October
21 June	25 October
28 September	21 November
7 November	22 November

To make a booking

Fundamentals in Clinical Audit e-learning programme live on www.hseland.ie

Email:
ncca@hse.ie
@hsencca

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

Connect with us!

- **nqps@hse.ie**
- **@NationalQPS**
- **#QIreland**
- **#PatientSafety**