

## **Reviews of patient safety incidents to be standardised and person-centred**

**Wednesday 25 October 2017:** The Health Information and Quality Authority (HIQA) and the Mental Health Commission (MHC) have today published new National Standards for the Conduct of Reviews of Patient Safety Incidents. The standards were jointly developed by HIQA and the MHC, and aim to promote an open culture in acute hospitals under HIQA's remit and mental health services under the remit of the MHC to ensure that services act in a transparent, standardised and person-centred way to review patient safety incidents and learn from them.

The standards emphasise the need to support and involve service users in the review of patient safety incidents and set timelines for services to follow when a patient safety incident occurs. For example, notifying the service's Senior Accountable Officer within 24 hours of identifying a serious incident; and completing external, independent reviews within 120 calendar days.

Commenting on the National Standards, Rosemary Smyth, the MHC's Director of Standards and Quality Assurance & Director of Training and Development, said: "Patient safety is an absolute priority, and the publication of these standards promotes a clear and transparent framework for reviewing patient safety incidents. They encourage an open approach to incidents, which ensure the patient is at the heart of every review. The standards acknowledge that sometimes things go wrong, but that lessons can be learned and shared across services, both locally and nationally, to improve patient safety."

Rachel Flynn, HIQA's Director of Standards and Health Information, said: "Service users and members of the public expect to be safe when using health and mental health services. These National Standards promote a person-centred approach to the review of patient safety incidents, supporting and communicating with service users and their families during any review, and ensuring reviews are completed within clear timelines that service users are aware of. The Standards also emphasise that the future quality and safety of patient care must be a priority."

The standards have been informed by a review of national and international literature; a number of meetings with the Standards Advisory Group comprised of service users, healthcare (including mental health) professionals, and representatives from the Department of Health, the Health Service Executive (HSE), the State Claims Agency, the Office of the Ombudsman and the Private Hospitals Association of Ireland; focus groups with service users, staff and management; and an extensive six-week public consultation. The Minister for Health, Mr Simon Harris TD, has approved the standards and is launching them at the National Patient Safety Office Conference today.

Read the standards, a background document and the statement of outcomes from the public consultation at [www.hiqa.ie](http://www.hiqa.ie) and [www.mhcirl.ie](http://www.mhcirl.ie).

## **Ends.**

### **For further information please contact:**

Marty Whelan, Head of Communications and Stakeholder Engagement, HIQA, 01 814 7480 / 086 2447 623 [mwhelan@hiqa.ie](mailto:mwhelan@hiqa.ie)

Aoibheann O'Sullivan, Murray, Mental Health Commission, 01 4980346 / 087 629 1453 [aosullivan@murrayconsultants.ie](mailto:aosullivan@murrayconsultants.ie)

### **Note to Editor:**

- Standards on the conduct of reviews of patient safety incidents were commissioned by the Department of Health and are underpinned by findings from the Chief Medical Officer's 2014 Report on Perinatal Deaths in HSE Midland Regional Hospital Portlaoise.
- The National Standards contains 20 standard statements under five themes:
  - Governance and Accountability,
  - Person-Centred Approach to Reviews of Patient Safety Incidents,
  - Workforce,
  - Reviews of Patient Safety Incidents,
  - Sharing the Learning for Improvement.
- Services must appoint a service-user liaison to communicate with service users and their families during the incident management and review process.
- The standards set the following time frames for reviews of patient safety incidents to be implemented by services:
  - concise internal reviews are completed no later than 60 calendar days after the decision to review has been made,
  - comprehensive internal reviews are completed no later than 120 calendar days after the decision to review has been made,
  - external independent reviews, commissioned by the service, are completed no later than 120 calendar days after the decision to review has been made.
- HIQA and the MHC received 47 detailed submissions on the draft national standards during the six-week public consultation.

### **About the Mental Health Commission**

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards

of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

#### About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.