Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

Improving Safety through learning

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EQUIPS Research Network 20 Jan 2026



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

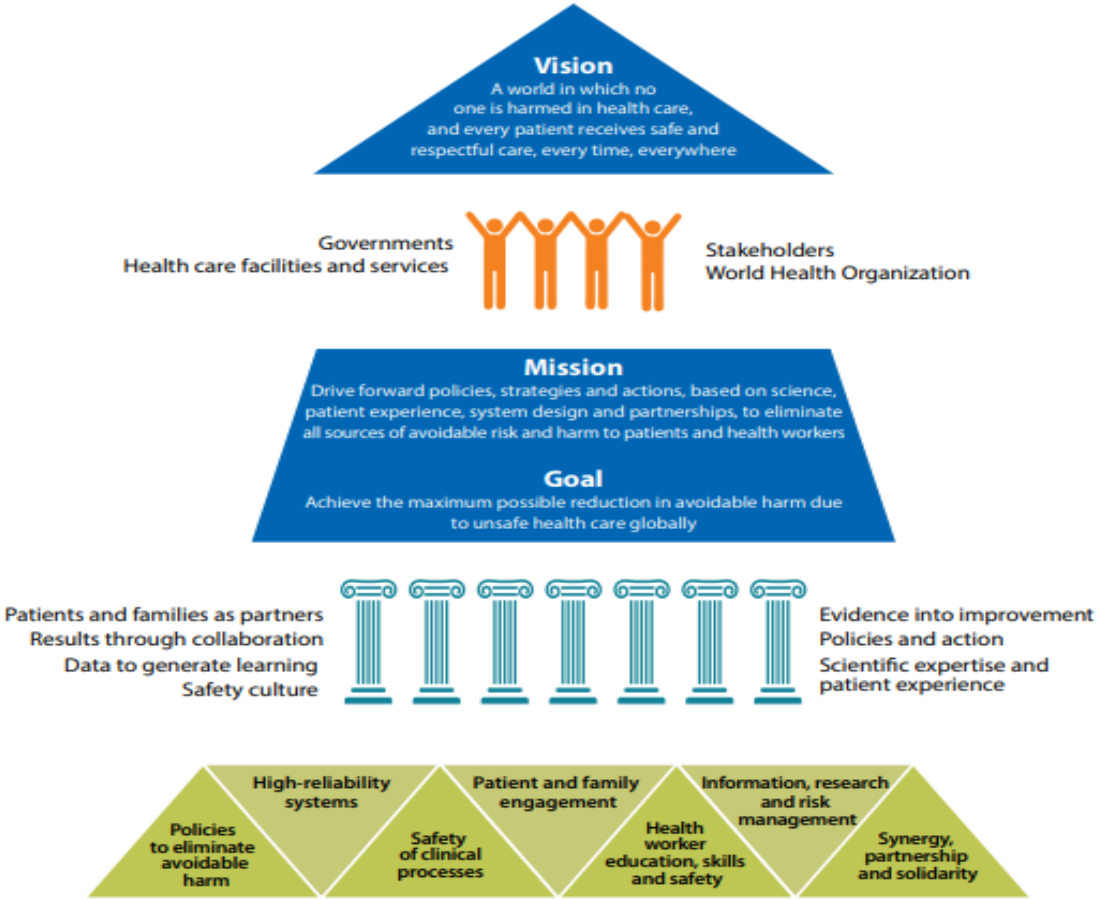
The GPSAP 2021-2030 was adopted by the 74th World Health Assembly in 2021.

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.



Global Patient Safety Action Plan 2021 -2030

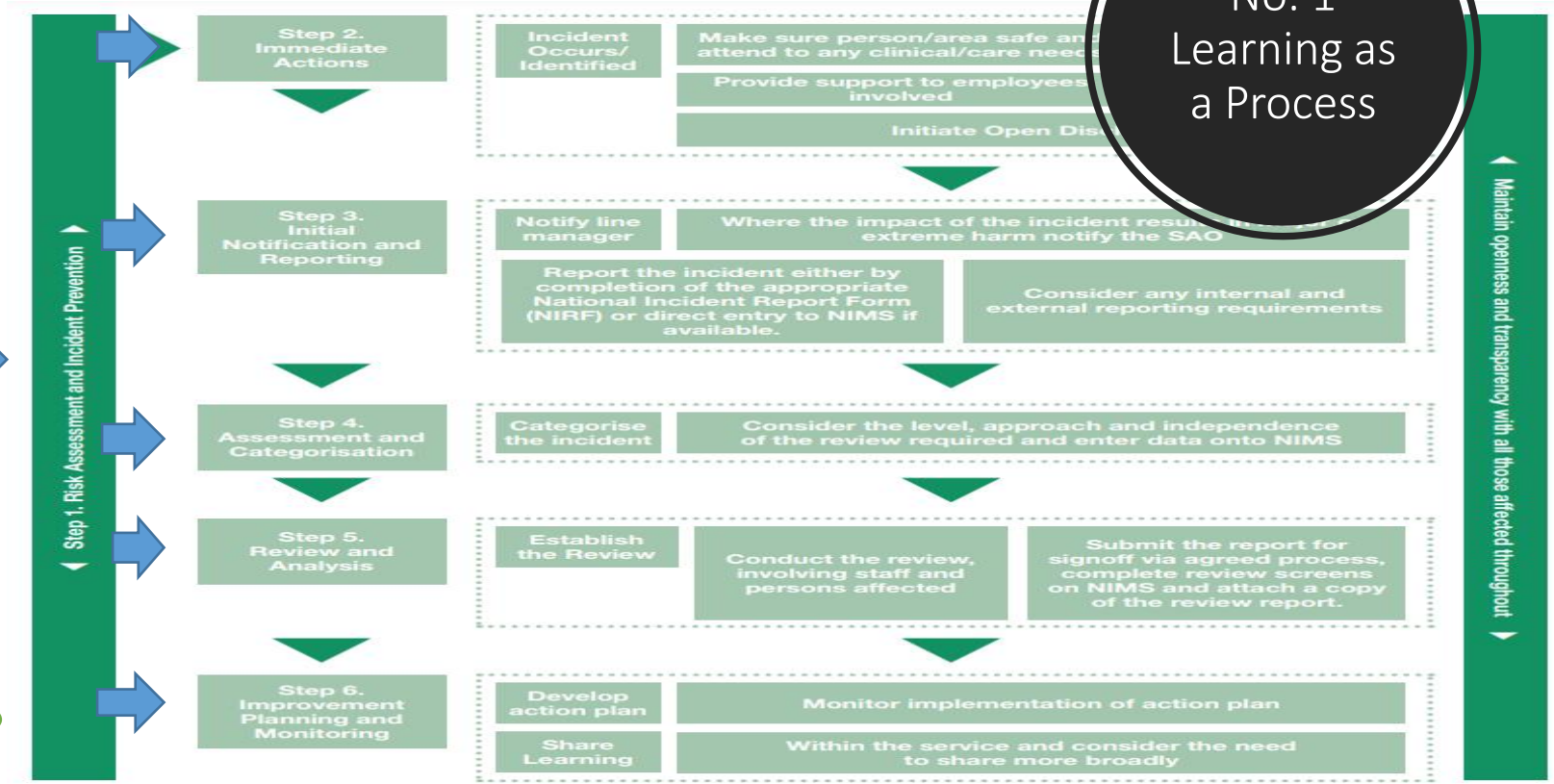


IM Principle

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

Incident Management Process

No. 1
Learning as
a Process



Learning from Excellence – Safety II

Learning as a Process

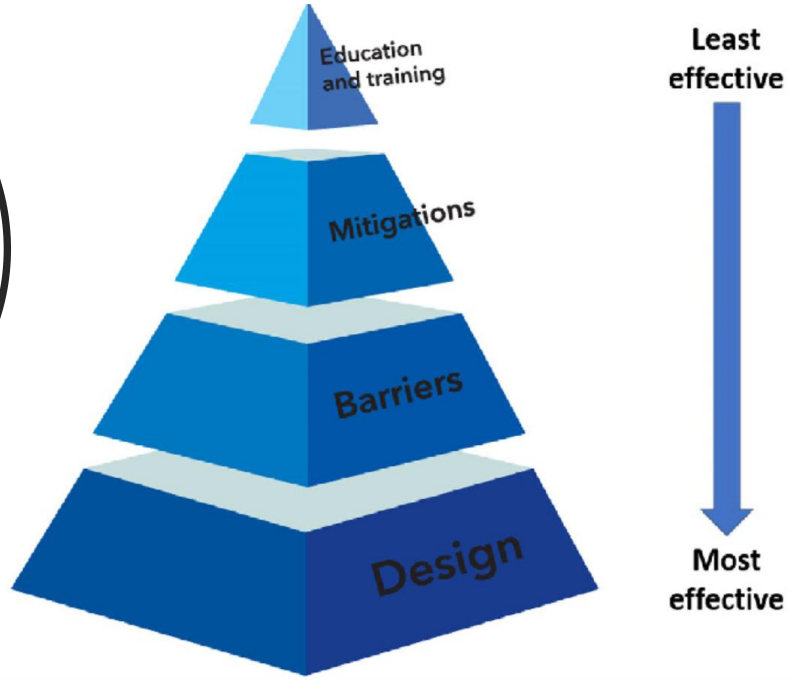
WHO 2020 Patient Safety Incident Reporting and Learning Systems Technical report and guidance - Uses and limitations of aggregated patient safety incident data

	ACTIVITY	SOURCE OF ANALYSIS	STRENGTHS	WEAKNESSES
	**Surveillance**	All incident types	Highlights broad patterns and trends	Weak on systemic insights; little immediately actionable
	**Performance assessment**	Incidents covering particular fields of care	Creates opportunity for system redesign and improved safety within a field of care	Requires extensive further investigation to assess nature of performance weaknesses
	**Breakdown in resilience**	Incidents pointing to failures in standards or control measures	Enables correction of breaks in defences	Causation can be wide ranging and restorative action complex
	**New and uncommon sources of serious harm**	Incidents of novel type showing clustering in time and space	Immediate opportunity to block harm and protect future patients	Needs highly active mining of data

Source: World Health Organization

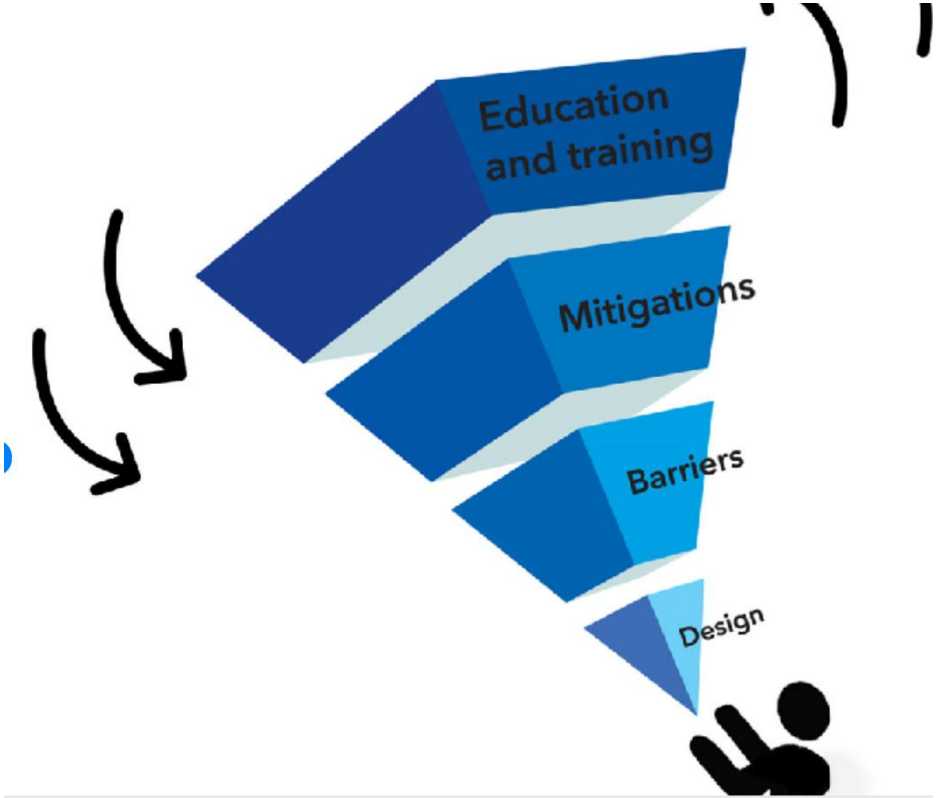
Hierarchy of Controls

No. 2
Learning as
an Outcome



Nick Sevdalis

Hierarchy of Controls as applied in healthcare



Nick Sevdalis

Design



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



Barriers

Patient Safety Alert

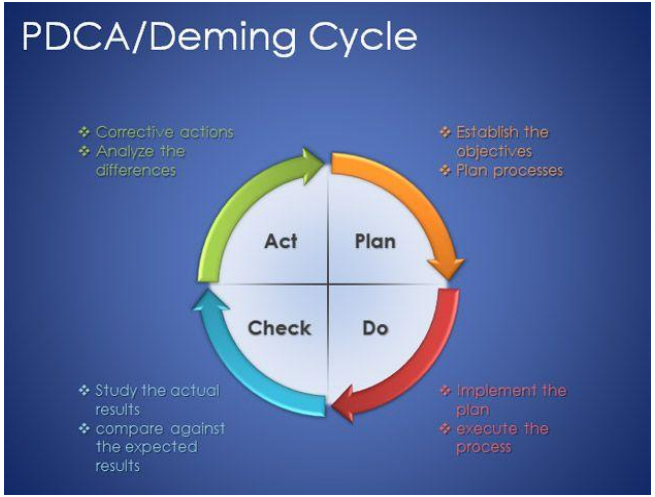
Reducing the risk of oxygen tubing being connected to air flowmeters

4 October 2016





FY2017/2018 - 16
FY2018/2019 - 30
FY2019/2020 – 50
FY2021/2022 - 13



SMART (specific, measurable, attainable, realistic, and time-sensitive)

Simulation

Working groups for on-going improvement

Assurance - Audit/Score card/outcome measures

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 specialty, complexity, lack of quality assurance processes

Anderson et al 2016

No. 3
Sharing
Learning

Patient Safety Together:
learning, sharing and improving



patientsafetytogether@hse.ie

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

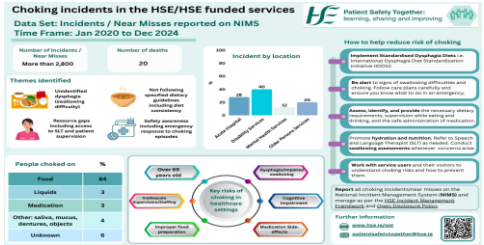


HSE National Patient Safety Alerts
High priority communications requiring services to take specific action(s) to strengthen patient safety





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

Communication Channels

















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