An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

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

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Patient Safety Together: learning, sharing and improving

Evaluation Plan

Version 2

QPSIM-PST 003

Contents

Version Control

Doc Control	Date	Version	Created by	Reviewed By	Approved By
QPSIM-PST-003	November 2022	Version 1	PST Learning Team	Assistant National Director, QPSIM Patient Safety Together Steering Group	Assistant National Director, QPSIM
QPSIM-PST-003	January 2024	Version 2 2.7 –Evaluation frequency changed from six monthly to yearly	PST Team	Assistant National Director, QPSIM	Assistant National Director, QPSIM

1. Introduction

Patient Safety Together: learning, sharing and improving (*Patient Safety Together*) is a sharing learning component of the patient safety programme to support the HSE Patient Safety Strategy 2019-2024. Patient Safety Together was developed in collaboration between multiple internal and external stakeholders who both use and work in health services in Ireland. Outputs from Patient Safety Together will be shared via an open access HSE web based platform. The platform is overseen by the Quality and Patient Safety Incident Management Team (QPSIM) of the National Quality and Patient Safety Directorate (NQPSD) and will provide up to date patient safety information for the purpose of sharing learning and supporting healthcare improvement. Through an agile and responsive approach, Patient Safety Together will support collaboration to ensure that the information on the HSE NQPSD website is accurate, valid and informative.

1.1 Objectives

The objectives of *Patient Safety Together* are;

1. to coordinate the identification, development and sharing of relevant patient safety information
2. to provide a national web based platform '*Patient Safety Together'* with collated patient safety information in an accessible format available to healthcare practitioners and the general public
3. to improve patient safety by sharing learning, raising awareness of patient safety risks, sharing solutions and seeking implementation of recommendations
4. to support those who use health services in Ireland and staff to easily access information on relevant patient safety issues
5. to demonstrate to persons involved in a patient safety incident that the HSE are actively sharing learning to help prevent similar incidents happening again,
6. to facilitate closing the loop on incident reporting by supporting sharing of learning for improvement purposes.

Through its webpage *Patient Safety Together* will host the following resources;

HSE National Patient Safety Alerts

- A searchable repository of **HSE National Patient Safety Alerts (NPSAs).** HSE NPSAs are high priority communications in relation to patient safety issues, which require HSE and HSE funded services 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. HSE NPSAs are issued by the HSE in conjunction with relevant stakeholders (subject matter experts, patient representatives, clinical and academic experts)

Patient Safety Supplements

- A searchable repository of **Patient Safety Supplements** (PSSs). PSSs are publications containing timely and relevant QPS information for learning purposes. The content of PSSs will be developed using up to date patient safety intelligence drawn from many patient safety sources including the analysis of incident reporting, reports from frontline services or new national or international research and evidence

Patient & Staff Stories -

- **Storytelling** aims to capture the experience of both patients and staff who have been involved in, or impacted by safety incidents. A guidance toolkit has been developed to support the art of storytelling

Signposting to further learning such as relevant conferences, QPS surveillance data, new QPS publications etc.

A special interest group of QPS professionals has been established via the 'Q Community' to further support the sharing of local experience and learning and to promote QPS improvement through discussion and peer support.

1.2 How *Patient Safety Together* will improve patient safety

A culture of learning is one of the cornerstones of improving patient safety. *Patient Safety Together* aims to support staff and organisations to identify, develop and share patient safety information and improvement strategies in a timely, consistent and effective manner.

Content will be developed from patient safety sources such as anonymised aggregated incident data from the National Incident Management System (NIMS), international incident data, healthcare research and coronial recommendations. Users will also be able to request further information and suggest areas to develop as content through patientsafetytogether@hse.ie The platform will also be capable of accommodating other sources of learning and information in the future.

2. Patient Safety Together Evaluation Plan

Evaluation is generally understood to be a planned investigation or using pre-determined questions about the impact of an innovation, how well it is being run and importantly what could be improved. This evaluation plan is based on the National Quality Improvement Team Self-Evaluation Guide (2017).

The approach to evaluation of *Patient Safety Together* will be matched to its principle objectives and the methodology being used to deliver the content. *Patient Safety Together* will be progressed through an agile and iterative approach to performance. It will therefore require ongoing feedback including through evaluation to inform the iterative development process. An **objective based, self-evaluation** is suited to this project but does not preclude the possibility of an impact based and/or external evaluation at a later phase of the project if required.

The self-evaluation will include both qualitative and quantitative information:

- Quantitative information
    - Measuring engagement with the HSE QPS eAlert system
    - Using Google Analytics to monitor:
        - Engagement metrics:
            - Visits
            - Downloads
            - Impressions
            - Link sharing
        - Task completion and findability (via navigation and search)
        - Retention metrics such as % of returning visits, and frequency of visits
- Qualitative information
    - Using direct feedback and survey data to include:
        - User-Journey feedback including experience of navigation, ease of use, search functionality and potential to triangulate information.
        - Content - analysis on usefulness, relevance, accessibility, readability and clarity of information provided

    This qualitative data will be collected through feedback from patientsafetytogether@hse.ie and surveys using SMART Survey with both end users using the website to access information and with those who use the platform to share learning, such as stakeholders who co-develop published content.

2.1 Benefits

Undertaking this evaluation will help *Patient Safety Together* in several ways:

- **Accountability:** Using the findings to demonstrate to stakeholders, what is being done and how well it is being carried out.
- **Assurance:** Using the findings to assure the Patient Safety Together Learning Team that the right information is getting to the right people in the right format at the right time.
- **Support decision-making and planning:** Using the findings to decide if innovations should be continued, improved, expanded or curtailed.
- **Learning and continuous improvement:** Using the findings to answer questions about what works and why it works.

2.2 Evaluation Process

The self-evaluation method of *Patient Safety Together* will use the following approaches;

1. Outcome

   An **outcome evaluation** will assess whether *Patient Safety Together* has resulted in targeted changes in the short or medium term. Outcome evaluations for *Patient Safety Together* will be concerned with:

   - Finding out what, if any, intended or unintended outcomes have occurred for the **target population** as a result of their participation with *Patient Safety Together* E.g. – evidence of increased sharing of learning within services through NPSAs, PSS or through the SIG.

2. Process

   A **process evaluation** of *Patient Safety Together* will assess how the programme was delivered, i.e. administrative or systems processes:

   - Focus on the implementation of *Patient Safety Together*;
   - Explore the programme aims - what is it supposed to do, has it done it?
   - The process experience of those who use the programme to share learning

A systematic approach to the self-evaluation process will be undertaken. Following completion of the evaluation cycle, data will be collated and reviewed by the QPSIM Learning Team. A six-monthly evaluation report will form part of reporting on *Patient Safety Together* to the

- Patient Safety Together Oversight Group

- Assistant National Director, QPS Incident Management
- National Clinical Director, NQPSD
- Chief Clinical Officer
- HSE Safety and Quality Committee

2.3 Identifying evaluation stakeholders and their evaluation interests

The initial step will be to identify stakeholders of *Patient Safety Together,* determine what their interests are, and how they might utilise the evaluation results.

Table 1: Programme Stakeholders

Who are the key stakeholders?	**What are their interests?**	**How will they use the evaluation?**	**Priority High / Medium / Low**
Patient Safety Together Learning Team / NQPSD	Oversight and management of the resources.	To utilise feedback to; determine the use of the resource among different stakeholder groups, determine if the content is meeting user needs (clarity and reliability of content, accessibility and useability of website), determine if content is reaching the target audience, inform improvements where required.	High
Patient Safety Together Oversight Group (former Steering Group)	Oversight and evaluation on the functionality and value of Patient Safety Together	To utilise feedback to determine if Patient Safety Together is developing and disseminating relevant and up to date information that is patient safety focussed. To	

		determine if the content is being regularly accessed across the HSE and its funded services. To consider any feedback received from users and how that might inform changes.	
HSE Digital	Oversight of website	To determine if; the content is accessible to users, the clarity of content and the useability of the website.	High
HSE Corporate	Require assurance on performance of strategies to improve patient safety in our health services	To gain assurance on performance and value of Patient Safety Together as a strategy for sharing learning to help improve patient safety	Medium
Healthcare Regulators	Awareness of patient safety information being disseminated to healthcare staff including actions required as part of HSE NPSAs	Evaluation reports will be available on request	Medium
Healthcare staff and Students	Gain access to reliable and up to date information and learning content to inform patient safety improvements	Evaluation reports will be available on request	Low
Patients/ Service Users/ Families	Gain access to reliable and up to date patient safety	Evaluation reports will be available on request	Low

	information and learning content		
Patient/ Service users advocacy groups	Gain access to reliable and up to date patient safety information and learning content	Evaluation reports will be available on request	Low
General Public	Gain access to reliable and up to date patient safety information and learning content	Evaluation reports will be available on request	Low
Academic and research staff	Use of content to support teaching and research	Evaluation reports will be available on request Low	Low

2.4 Data Collection Plan

Evaluation works best when stakeholders are clear about its aim and how the evaluation will be conducted. Evaluation can take many forms, but in all cases, information needs to be gathered in a timely and reliable way.

- The aim of this self-evaluation is to identify the strengths and areas for improvement of *Patient Safety Together* to ensure stakeholder needs are met by:
    - Monitoring site visits
    - Monitoring downloads and sharing of content
    - Monitoring number of outputs through *Patient Safety Together* via NPSAs, PSSs, Safety Stories etc.
    - Monitoring and actioning feedback received through all routes

The following sources of information or 'data' that are needed to conduct each self-evaluation are captured in Table 2.

Table 2: Data Collection Plan

What do I want to measure?	Who from?	When, how often?	Method (Data Collection Tool)	Who will collect the data?
Number of site visits	All Users	Monthly	Google Analytics	PST Learning Coordinator

Number of downloads and sharing of content	All Users	Monthly	Google Analytics	PST Learning Coordinator
Number of outputs through PST via NPSAs, PSSs, Safety Stories etc.	All Users	Monthly	Google Analytics	PST Learning Coordinator
Feedback on any element of PST received through all routes	All Users	Six monthly	PST Email Smart Survey	PST Learning Coordinator

2.5 Data Management Plan

When the data collection plan is agreed, the data collection tools will be designed and developed, e.g. surveys and questionnaires. Table 3 below outlines a high-level data management plan. This plan sets out how to manage the data, including information on who will collect the data, who will enter it into analysis software (if being used), who will complete the data analysis, any software and hardware required, and any staff training/ orientation requirements needed to analyse the data. This is a high-level plan and it may be necessary to update this data management plan and refine data collection tools as the self-evaluation develops.

Table 3: Data Management Plan

Type of data collected	**Data collected by**	**Date Entry / Write –up / Analysis By**	**Software/Hardware used?**
Data Analytics	PST Learning Coordinator / HSE Digital Team	PST Learning Team	Google Analytics
Survey Results	PST Learning Coordinator		Smart Survey
Feedback received via patientsafetytogether@hse.ie	PST Learning Coordinator		Outlook
Ad-hoc feedback – written and verbal	PST Learning Coordinator		Various

2.6 Communication of the Evaluation Findings

The evaluation results will be communicated to:

- facilitate understanding of *Patient Safety Together* evaluation findings among stakeholders
- help ensure high-quality services are provided through using results to inform improvements
- support decision-making e.g. whether *Patient Safety Together* is meeting end-user needs
- ensure transparency of, and accountability for the programme is clear.

The self-evaluation findings will be communicated in a way that is suitable to ensure that there is enough detail for stakeholders to make informed judgements.

Table 4: Communication of Findings Plan

Stakeholder	**What do you want stakeholders to do with the findings**	**What findings do you need to communicate?**	**Communication methods / channels / activities**	**Timeline**
Patient Safety Together Learning Team / NQPSD	Inform content strategy. Make required improvements.	Website analytics (traffic, downloads etc.), User satisfaction, Suggestions for improvement.		Monthly
HSE Digital	Make required improvements.			Quarterly
HSE Corporate	Use data to inform QPS strategies.		Update report to PST Oversight Group /Assistant National Director NQPSD/ National Clinical Director	Six monthly

			NQPSD/ Chief Clinical Officer/ Safety and Quality Committee of the HSE Board	

2.7 Evaluation Report

A full evaluation report will be produced six monthly that details all of the evaluation methods and findings, it can be used to inform the development of other resources, such as briefing papers and summaries.

The six-monthly evaluation report will form part of reporting on *Patient Safety Together* to the

- Patient Safety Together Oversight Group
- Assistant National Director, QPS Incident Management
- National Clinical Director, NQPSD
- Chief Clinical Officer
- HSE Safety and Quality Committee.

Headings to include in the evaluation report of *Patient Safety Together*.

- **Abstract:** A short paragraph detailing what was evaluated, how it was evaluated, how many participants took part and what the main results were.
- **Executive Summary:** To provide a short, plain language summary of the main results observed, the conclusions and the recommendations.
- **Introduction:** To outline the aims, objectives and motivations for the evaluation and a review of the literature in the area (if appropriate). It should also include a description of the initiative and the context in which it is delivered.
- **Methodology/Design:** Describing the methods used to collect data, the participants who took part, and how data were analysed.
- **Results:** Outlining the results observed
- **Discussion:** To discuss possible reasons and explanations for the results observed in the evaluation and any other evidence to support these findings.
- **Conclusion:** To summarise the main findings observed, and contain recommendations for policy, practice and future research and initiatives.
- **Appendices:** Including copies of any measurement tools used, such as surveys/questionnaires and observation frameworks.

- **References:** Including the authors, titles and publication details of any publications or websites drawn on for the report. When referencing a website, the URL address and the date it was accessed will be included.

3. Using Evaluation Results to Support Improvement

The evaluation findings will inform the Patient Safety Together Learning Team and NQPSD if *Patient Safety Together* is delivering on its objectives and/or if changes or improvements are indicated. The findings will also be interrogated to identify potential ways for Patient Safety Together to support patient safety improvements and continuous quality improvement at local and national level.