Implementing a Systems Approach to Patient Safety Course

PROGRAMME

Day 1 —

10.00 **Registration**

Welcome and introduction to the course

Healthcare Quality Quest course leader
Participants share their backgrounds and personal learning objectives

Patient safety — An overview of a systems approach — *An introduction to systems analysis, Safety I versus Safety II concepts, the key components of a robust proactive and reactive patient safety programme, how the components link, and how the NHS and WHO Patient Safety Strategies fit in*

Brief presentation
Participants complete a self-assessment of the current performance of the patient safety programme in their organizations

11.15 **Break**

11.30 **Patient safety — An overview *(continued)***

Appreciating good patient safety practices — *How to apply Safety II thinking and implement methods and tools to recognize and support current excellent patient safety practices*

Brief presentation

12.30 **Lunch**

13.30 **Appreciating good patient safety practices *(continued)***

Participants identify the methods currently used routinely in their organizations to recognize good patient safety practices and consider how they could be enhanced

Assessing and managing risks and issues — *How to identify, assess, handle, escalate and document risks and issues*

Brief presentation
Participants practice identifying and describing risks and issues properly, assessing risks and issues, setting targets for risk reduction, selecting appropriate risk handling strategies and making entries in a risk register

15.00 **Break**

15.15 **Assessing and managing risks and issues *(continued)***

17.00 **Adjourn for the day**

HEALTHCARE QUALITY QUEST

Day 2 —

08.45 **Reflections on learning**

Participants summarize their personal learning points from Day 1 in their Learning Diaries and discuss any questions with the course leader

09.00 **Convene**

Major points from Day 1

Participants and the course leader reflect on learning from Day 1 and questions

Using Failure Mode and Effects Analysis — *How to prevent an adverse event by proactively changing a high-risk process or system to make it safer for patients*

Brief presentation
Participants identify a high-risk process or system from their work on risk assessment and diagram how the process or system is supposed to work and how it usually works

10.45 **Break**

11.00 **Using Failure Mode and Effects Analysis *(continued)***

Brief presentation
Participants identify where the high-risk process or system could fail, rate the potential consequences of failure, identify potential causes of failure and a patient safety improvement to be achieved

12.30 **Lunch**

13.30 **Assuring implementation of evidence-based patient safety practices — *How to assure if patient safety alerts and evidence-based patient safety practices are being implemented routinely, using a run chart, a clinical audit or a checklist***

Brief presentation
Participants identify the evidence available in their organizations on implementation of evidence-based patient safety practices and decide if patient safety assurance could be strengthened

15.00 **Break**

15.15 **Assuring implementation of evidence-based patient safety practices *(continued)***

Involving patients and families in the patient safety programme — *How patients, families and carers can contribute to patient safety through incident reporting, always events, patient feedback on safety, and patient involvement in patient safety activities*

Brief presentation
Participants decide how patients and their representatives could be more actively involved in patient safety in their organizations and what approaches could be implemented

17.00 **Adjourn for the day**

Day 3 —

08.45 **Reflections on learning**

Participants summarize their personal learning points from Day 2 in their Learning Diaries and discuss any questions with the course leader

09.00 **Convene**

Major points from Day 2

Participants and the course leader reflect on learning from Day 2 and questions

Reporting and analysing incidents — *Using data from incident reports to make better use of key themes, using methods for involving staff in analysis of no-harm and low-harm incidents, analysing a serious incident properly, and implementing the Patient Safety Incident Response Framework*

Brief presentation
Participants consider how incident reports are currently used for improvement purposes and carry out initial stages of the analysis of a serious incident

10.45 **Break**

11.00 **Reporting and analysing incidents *(continued) — What's involved in using the Systems Engineering Initiative (SEIPS), AcciMap and other analytic tools***

Brief presentation
Participants continue analysis of a serious incident, including analysing the process or system involved and why the breakdowns in the process or system happened, and identify the patient safety improvements to be achieved

12.30 **Lunch**

13.30 **Reporting and analysing incidents *(continued) — A summary of key points from the Patient Safety Incident Response Framework***

Brief presentation
Participants continue work on the analysis of a serious incident

15.00 **Break**

15.15 **Learning from complaints — *How to reflect on types of complaints being made and the issues they represent and process and analyse a complaint properly***

Brief presentation
Participants select a complaint they may have experienced or know about and go through the stages of proper processing and analysis of the complaint, and identify the improvement/s in performance to be achieved from the analysis

17.00 **Adjourn for the day**

Day 4 —

08.45 **Reflections on learning**

Participants summarize their personal learning points from Day 3 in their Learning Diaries and discuss any questions with the course leader

09.00 **Convene**

Major points from Day 3

Participants and the course leader reflect on learning from Day 3 and questions

Learning from deaths and medical examiner experiences — *How to integrate findings from death reviews and medical examiner experiences into the patient safety programme*

Brief presentation
Participants reflect on the processes used in their organizations to analyse patient deaths and learn from medical examiners any part/s of the processes where improvements could be made

10.45 **Break**

11.00 **Using existing published and organizational patient safety-related data for improvement — *Using published data as well as local data from clinical audits and quality assurance checks to identify needed patient safety improvements and linking data to possible patient safety improvement projects***

Brief presentation
Participants reflect on how data from various sources are analysed and synthesized to find needed patient safety improvements

12.30 **Lunch**

13.30 **Applying quality improvement approaches and tools to patient safety improvement — *An overview of the QI process and what's involved in carrying out an improvement project, the role of teamwork in improvement, how to get a team to agree on an improvement objective, testing commitment to achieving an improvement, and tools for establishing a baseline of current practice and its effects***

Brief presentation
Participants select a possible patient safety improvement idea and develop the idea as an improvement project through measuring the effects of current practice

15.00 **Break**

15.15 **Applying quality improvement approaches and tools to patient safety improvement *(continued)***

17.00 **Adjourn for the day**

Day 5 —

08.45 **Reflections on learning**

Participants summarize their personal learning points from Day 4 in their Learning Diaries and discuss any questions with the course leader

09.00 **Convene**

Major points from Day 4

Participants and the course leader reflect on learning from Day 4 and questions

Applying a 'theory of change' for patient safety improvement — *What works to achieve change, implications of the recent evidence base on what it takes to change practice in clinical practice and a systematic approach to achieving and sustaining change for patient safety*

Brief presentation
Participants decide on a change in practice related to patient safety to be achieved, identify the nature of the changes involves, select change strategies and plan their implementation in detail

10.45 **Break**

11.00 **Assessing the organization's patient safety culture and identifying actions needed in the organization — *A summary of organizational culture concepts and tools for measuring patient safety culture in a healthcare organization***

Brief presentation
Participants reflect on the patient safety culture in their organizations and how the culture could be strengthened

Engaging the workforce in patient safety — *An overview of approaches used to actively involve staff in patient safety and patient safety-related issues affecting staff*

Brief presentation

12.30 **Lunch**

13.30 **Engaging the workforce in patient safety *(continued)***

Participants decide if any of the approaches used to further involve staff in the patient safety programme can be implemented in their organizations

Planning to improve patient safety systems and performance — *Actions needed to achieve improvements and how they will get done*

Participants plan how to use their learning about patient safety to achieve improvement in the way a patient safety activity works in their organizations

Summary of course, questions and course evaluation

Brief summary
Participants complete an evaluation of the course

15.30 **Adjourn**