## O'Donnell, Bridget

From:

McLean Rebecca

Sent:

11 October 2004 09:39

To:

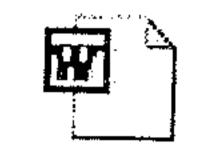
Bridget.O'Donnell

Subject:

FW: Please confirm Info for participants

Importance:

High



2dayprog.doc

This message is bound by the disclaimer below.

Breidget - Here you go, as discussed for Jayne or Ann's comments. Rebecca

----Original Message----

From: McLean Rebecca

Sent: 07 October 2004 14:47

¬o:

; Cody Diana

abject: FW: Please confirm Info for participants

Importance: High

----Original Message----

From: McLean Rebecca

Sent: 07 October 2004 14:44

To:

Cody Diana;

Subject: Please confirm Info for participants

Importance: High

Dear all

Following yesterdays meetings and following several requests from participants to confirms dates for programme, I would be grateful if you could advise if you are happy for me to confirm dates with those individuals named yesterday (Given it is only 4 weeks away!) I would also be grateful if you could advise of your comments/amendments on the document drafted by Sue and discussed by yourselves on the 2/3 August, as it was agreed at that meeting that this document would be distributed to participants with the confirmation letter. would really need to send out confirmations as soon as possible, i.e. Monday 11th,

Just to remind everyone of those named yesterday to attend the 9th and 10th Nov (LC Case study being used in this one).

Mr Hugh Mills - Chief Executive

Esther Millar - Woman and Children's Services Director

Gerry McLaughlin - Human Resources Director

Eugene Fee, Director of Acute Hospital Services

erefore please provide me with comments ASAP.

Bridget O'Rawe - Director of Corporate Affairs

Dr Jim Kelly, Medical Direct (during that time)

Christine Millar - Complaints Assistant

Janet Hall - Communication & Public Affairs Manager

Teresa Murray - Risk Management Co-ordinator

Kevin Doherty - Litigation Services Manager

Donna Scott - CSA, Legal Advisor

Claire Thompson - Medical Records

Dr Jarlaith O'Donohoe - Consultant Paediatrician

Dr Clive Burgess - Occupational Health

Dr Treavor Anderson - Clinical Director (during that time)

Dr Tom Auterson - Consultant Anaethetist

Dr Connor - Is this Dr Elaine Connor of Erne Health Centre???

Dr David McManus, Ni Ambulance Service

S/N Sally McManus

S/N Brid Swift

S/N Thelca Jones S/N Teresa McCaffrey Sr MacNeil

Please note (as advised by woman & children's service director) that Sr Etain Traynor (children's ward) no longer works for the Trust.

Please advise me of any changes that I need to bear in mind.

Regards

Rebecca McLean

Strathdene House

Tel:

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Safer Systems and Processes - Root Cause Analysis using a Human Factors Approach

2 Day Development Programme:

9<sup>th</sup> - 10<sup>th</sup>; 11<sup>th</sup> - 12<sup>th</sup> and 15<sup>th</sup> - 16<sup>th</sup> November 2004

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Patient care, like other technically complex and high risk services, is an interdependent process carried out by teams of individuals with advanced technical training who have varying roles and decision-making responsibilities. While technical training assures proficiency at specific tasks, it does not address the potential for error deriving from communication and decision making in dynamic environments.

NHS organisations should have in place a holistic and integrated system covering management, reporting, analysis and learning from all adverse incidents involving patients, staff and others. The challenge is to change cultures and move towards a just, honest and open approach to incident reporting so that staff are involved and secure in sharing their experiences.

It is important for health care organisations and their staff to establish the underlying causes of adverse incidents, errors and near misses. Unless the causes of an adverse patient experience are properly understood lessons will not be learned and required changes will not be made to reduce the risk of harm to future patients.

In response to these challenges, the aviation industry has developed training focussed on effective team management known as Crew Resource Management (CRM). The concepts originated from NASA research that examined the role that human error plays in aircraft accidents. CRM training considers the role of human factors in high-stress, high-risk environments. During the past decade lessons from aviation's approach have been applied to the health care industry and its approaches to patient safety.

This programme sets out the key requirements for Health and Social care organisations to manage, report, analyse and LEARN from ALL adverse patient incidents.

This root cause analysis development programme will provide participants with the skills and expertise to effectively apply the principles and learning from error management techniques. A workshop approach is used to allow the participants to share information and experience.

## Programma Contiant

The two day facilitated learning sessions will cover:

- How to improve communication and interpersonal relationships within clinical teams
- How to support staff through the investigation process following an adverse patient safety incident
- How to address communication and public relations issues
- How to develop a robust risk assessment framework for patient safety incidents
- How to engage staff in error management
- How to undertake a root cause analysis using a human factors approach
- How to formulate resulting action plans
- How to identify the lessons learnt and select appropriate methods for dissemination
- How to address cultural change issues

All course participants will receive relevant handouts, including:

- Examples of good practice
- Exemplar proformas for adaptation and use in own work place
- A bibliography of recommended further reading, a list of useful websites and other resources
- Certificate of Attendance/CME Points

o)ne	
09:15	Registration and Coffee
09:30	Welcome and introduction  Domestic arrangements  Syllabus and Programme objectives
09:45	Patient Safety – the bigger picture Review of national reports and agencies Statistical evidence & the case for change The role of the National Patient Safety Agency
10:15	Lessons learnt in Aviation  Air safety developments  Principles, approaches & concepts  Aviation case-study
10:45	SHEL – Human Factors Model What affects human performance?
11:00	Morning refreshments
11:15	Human performance and limitations What causes us to make mistakes?
11:45	Communication  Dealing with the media and public relations  Skills & strategies to improve communication  Keeping staff informed
12:15	Classifying Patient Safety Incidents  Agreeing definitions and classifications  Review of local policies and procedures
12:30	Lunch
13:15	Root Cause Analysis - Health and Social Care Case-study 1 Techniques for gathering the evidence
15:00	Afternoon refreshments
15:15	Health and Social Care Case-study – 1 Root Cause Analysis definitions, tools and models
17:00	Close

Two	
09:15	Coffee and welcome
09:30	Review of Day One & Introduction to Day Two
09:45	Healthcare & Social Care Case-study 2  Identifying causal factors  Mapping exercise  The Error Chain
11:15	Morning refreshments
11:30	Feedback from Root Cause Analysis exercise
12:00	The causal report  Agreeing the causal factors  Analysis of causal factors
12:45	Lunch
13:30	Writing the Action Plan  Agreeing action with roles and responsibilities  How to track progress
14:15	Personal Lessons learned/transfer to the workplace Individual action planning
15:00	Afternoon refreshments
15:15	Changing the culture, systems & processes  Identifying methods to share experience and information Opportunities for integration Improving teamwork and interprofessional relationships
16:00	Next steps Sharing lessons learnt What will I do differently tomorrow? What should the organisation do differently tomorrow?
16:30	Programme review  Arrangements for follow-up day and presentation of action plan
17:00	Close