## O'Donnell, Bridget

**From:** McLean Rebecca [redacted]
**Sent:** 11 October 2004 09:39
**To:** Bridget.O'Donnell [redacted]
**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
To: [redacted]; Cody Diana
Subject: FW: Please confirm Info for participants
Importance: High

-----Original Message-----
From: McLean Rebecca
Sent: 07 October 2004 14:44
To: [redacted] Cody Diana; [redacted];
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.
I would really need to send out confirmations as soon as possible, i.e. Monday 11th, therefore please provide me with comments ASAP.

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
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: [redacted]



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GLOBAL AIR TRAINING

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

## 2 Day Development Programme :

$9^{th}$ - $10^{th}$; $11^{th}$ - $12^{th}$ and $15^{th}$ - $16^{th}$ November 2004

## Introduction

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.

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## Programme Content

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

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## Day One

**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*

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## Day 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*

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