

Using Incident Analysis to Improve Patient Safety Workshop



E	09.00	Registration
		Welcome and introductions <i>Representative of the healthcare organization</i> <i>Healthcare Quality Quest workshop leader</i>
M		The need for analysis of incidents — An overview of benefits and drawbacks of analysing an incident, important points from the evidence base on how a typical analysis of an incident can fail to improve patient safety and how the NHS England Patient Safety Incident Response Framework (PSIRF) fits in <i>Brief presentation</i> <i>Participants discuss their experiences with analysing an incident, if any</i>
		How to seek all the facts about an incident and obtain information needed — The first two stages in the analysis process <i>Brief presentation</i> <i>Participants carry out initial steps in an analysis of an incident or a near miss</i>
M	10.45	Break
	11.00	How to seek all the facts about an incident and obtain information needed (continued) How to learn about relevant systems or processes — Consideration of human factors and intended, usual, actual systems or processes related to the incident <i>Brief presentation</i> <i>Participants analyse systems or processes involved in an incident</i>
A	12.30	Lunch
	13.30	How to learn about relevant systems or processes (continued) How to validate the analysis and identify problems and their causes — Finding exactly what caused and contributed to the incident <i>Brief presentation</i> <i>Participants use tools to describe problems, causes of and contributing factors for an incident</i>
R	15.00	Break
	15.15	How to validate the analysis and identify problems and their causes (continued) How to identify the patient safety improvement needed, establish and implement the right actions to achieve the improvement and determine the effectiveness of actions taken — Strategies for acting on the findings of the analysis and measuring if actions made things safer for patients <i>Brief presentation</i> <i>Participants plan action for the analysis completed and measurement of the effectiveness of action</i>
G	16.30	Workshop evaluation and adjourn
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