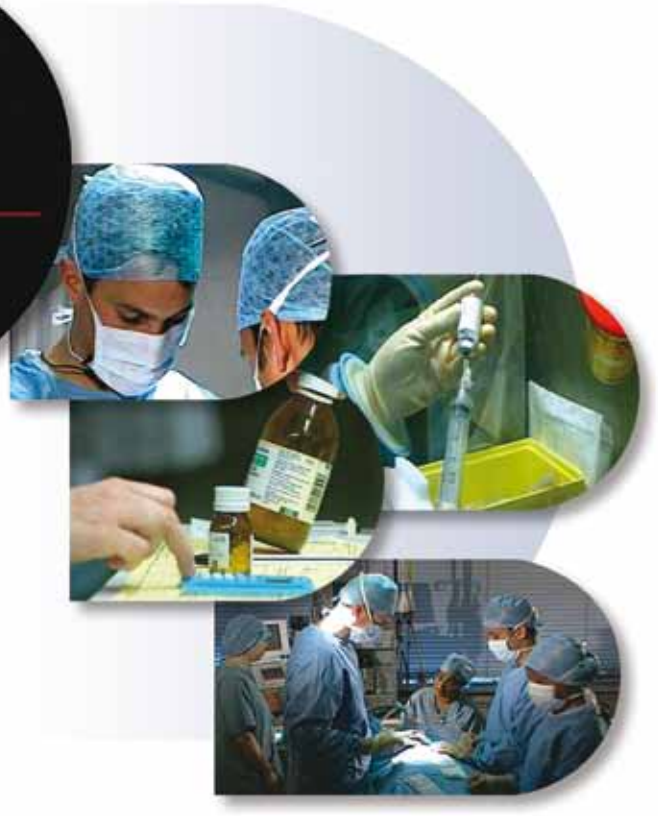
DELIVERING PATIENT SAFETY



With the increase in patient incidents in Australia, the Delivering Patient Safety training package is timely in bringing to you valuable information to effect and implement change, improve quality control measures, and mitigate risk.

Delivering Patient Safety is a world first, bringing together on-screen international leaders and day-to-day practitioners of patient safety, in a training package for hospitals, medical schools, and organisations who have the responsibility of removing the cause of error before there is harm to the patient.

Delivering Patient Safety addresses questions of change in practice, culture, management and systems that are fundamental to this concern.

Delivered by Professor James Reason, an internationally recognised expert in human error management, and other leading worldwide experts with frontline responsibilities, the program has been developed for healthcare professionals with the responsibility of identifying and resolving the causes of error, thus preventing harm to the patient. It is designed for system wide use and can be used by the non-specialist for Staff Training Sessions.

The training package contains 5 DVD programs and a support material CD.

"This multimedia resource is an excellent tool that can be used to educate providers, healthcare leaders and healthcare boards throughout the system."
Canadian Patient Safety Institute

How do I use the series?

Online
- Available 24/7
- Global access
- Self-assessment

On screen
- Broadcast quality
- Cultural change
- Raise awareness

In print
- Large format
- Training
- Reference

Local opportunities – local resources

The series provides for different approaches, to match local opportunities and local resources. Begin with the User's Guide – identify the most appropriate strategy for you:

Targeted initiatives among individual groups in: medicine, surgery, nursing, pharmacology, management and support staff.

Phased the introduction of error management measures according to immediate priorities and resources of time, money and opportunity.

Systemic strategic initiatives to address error management issues throughout the institution.

Delivering Patient Safety is currently being used in Brazil, Canada*, Denmark, Iceland, Ireland, Scotland, Singapore, Sweden, UK** and USA.

** Used by over 1,000 participant groups as a learning tool to meet national accreditation standards.*

*** Used in over 600 NHS hospitals in the UK.*

"It's a devastating and harrowing experience for a clinical team to lose a patient through an error which is potentially avoidable." Professor Liam Donaldson, Chief Medical Officer, Department of Health, UK.

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"How can we begin to tackle medical error? What is it that doctors and nurses and clinical teams can start doing tomorrow to improve the situation?" Professor James Reason

"The objective is not to make perfect people, but to stop mistakes from hurting people."
Lucian Leape, MD, Harvard School of Public Health

STAGE 1

Facing the facts

- 1 million preventable injuries and 98,000 deaths a year in US hospitals. Studies in the UK, Australia, New Zealand and Denmark show a startling similarity, with 10% of hospital patients being harmed.
- Why do such things happen to good people trying to do a good job?
- Healthcare professionals fear catastrophic human failure, so why do many organisations have no systemic measures to manage error?

STAGE 2

Changing the culture

- Creating a just culture.
- Changing relationships - identifying hazards ahead of time.
- Which teams have the best outcomes?
- Why self criticism is vital - a 6 Point Cultural Health Check.

STAGE 3

Why things go wrong

- We can't eliminate error but we can manage it.
- Why relying on a good safety record can be dangerous.
- The Person Model vs The System Approach.
- Good outcomes, like bad outcomes, are a team effort.

STAGE 4

Building resistance to error

- Why do different kinds of people make the same kinds of error?
- Removing error traps.
- Making Medication Safer - the Trigger Tool - Barcodes.
- Stopping errors from hurting people.

STAGE 5

A safer system

- Sick patients in sick systems - Why blame doesn't work.
- The danger of learned helplessness - Crude data - crude outcomes.
- Error management at every level: individual - team - institution.
- Investing in Safety - A Lifelong Commitment.

Support material

- PowerPoint presentations and resource materials created by Professor James Reason to accompany the series.
- Support material expands on issues covered in each program and offers expertise from the wider world of error management.
- All material is customizable to suit local needs and local resources.

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