Learning from adverse events workshop

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

27-28 March 2019

Waipuna Hotel and Conference Centre, Exhibition Hall,
58 Waipuna Rd, Mount Wellington, Auckland

Wednesday, 27 March 2019		
Time	**Session**	**Presenter**
8:15am	Registration opens	
8:50am	Mihi whakatau	
9:00am	Welcome from local host	**Gloria Johnson,** Chief Medical Officer, Counties Manukau Health
9:10am	Welcome from the Commission	**Caroline Tilah,** Manager Patient Safety, Health Quality & Safety Commission
9:15am	The consumer experience *Participants will appreciate the impact of an adverse event on a consumer and their whānau and the implications for their future interactions with the healthcare system.*	**Heather Gunter** and **Karyn Bousfield**, West Coast DHB
9:45am	The National Adverse Events Reporting Policy 2017 *Participants will appreciate the purpose, scope, key principles and approaches of the Policy, and what has changed from the previous Policy.*	**Glen Mitchell,** Adverse Events Specialist, Health Quality & Safety Commission
10:15am	***Morning tea***	
10:45am	The role of open communication - the patient safety landscape *Participants will understand the principles of open communication and identify how this principle can be better applied in their own organisation.*	**Dr David Hughes**, Clinical Lead, Adverse Events Learning Programme, Health Quality & Safety Commission
12:15pm	***Lunch***	

Wednesday, 27 March 2019		
Time	**Session**	**Presenter**
1.15pm	An introduction to Human Factors *Participants will appreciate the:* • *science of Human Factors and how human factors can be used in the design of safer systems* • *nature of human error and the role of human factors in reducing likelihood and mitiqating consequences of error* • *relevant of Human Factors science to prevention of adverse events in healthcare* • *appreciate how a just culture stands apart from disciplinary processes or a protected quality assurance activity, and how it adds value to improving patient safety.*	**Bob Henderson**, Human Factors Specialist, Health Quality & Safety Commission
2:45pm	***Afternoon tea***	
3:00pm	Meeting the needs of Māori in adverse event review *Participants will appreciate the:* • *importance of meeting cultural needs of Māori in adverse event review processes* • *consider tools and approaches to meet the cultural needs of Māori in adverse event review.*	**Taima Campbell,** RN, MHSc (Nsg), PG Dip Bus (Māori Dev), Director Hauraki Health Consulting Ltd
4:30pm	***Day one close***	**Caroline Tilah**
4:45pm	Networking function	A networking function will be held at the Waipuna Hotel and Conference Centre. Nibbles will be provided; drinks at own cost.

Thursday, 28 March 2019		
Time	**Session**	**Presenter**
8:00am	Tea and coffee available	
8:30am	Welcome back and recap	**Caroline Tilah**
8.45am	Supporting staff involved in an adverse events *Participants will:* • *consider how adverse events may affect staff* • *consider tools and strategies for mitigating the impact of adverse events on staff* • *appreciate services available to support staff when adverse events happen* • *appreciate how organisations can promote a just culture and prevent victimisation of staff* • *understand current approaches to patient safety.*	**Dr David Hughes**
9.45am	Consumer participation in adverse event review *Participants will appreciate:* • *the importance of engaging with consumers around adverse event review* • *opportunities and approaches to engaging with consumers through the review process.*	**Louise Allsopp**, Manager of Patient Safety and Service Quality, Whanganui DHB
10:15am	***Morning tea***	
10:45am	An introduction to adverse review processes *Participants will:* • *appreciate the key principles of an adverse event review* • *appreciate different review methodologies and when they might be used* • *understand the steps in an adverse event review process*	**Sandy Blake**, Director of Nursing and **Louise Allsopp**, Manager of Patient Safety and Service Quality, Whanganui DHB
11:00am	Step 1: Getting started *Group exercise 1* Step 2. Gather and map information *Group exercise 2* *Based on a given scenario, participants will:* • *develop a brief event review flow diagram* • *identify additional information requirements* • *identify tools and protocols required to gather additional information* • *develop a detailed event review flow diagram that establishes the event chronology*	**Sandy Blake** and **Louise Allsopp**

Thursday, 28 March 2019		
Time	**Session**	**Presenter**
12:00pm	Step 3: Identify care and service issues Step 4: Analyse the problem and identify causal factors *Group exercise 3* *Based on a given scenario, participants will:* • *undertake an analysis of the barriers that may have been breached in order to identify the care and service issues* • *identify contributing and causal factors using tools commonly used in adverse event review*	**Sandy Blake** and **Louise Allsopp**
1:30pm	***Lunch***	
2:15pm	Step 5: Generate solutions and recommendations Step 6: Log, audit and learn from review reports *Participants will:* • *based on a given scenario, generate and write recommendations, including a measure* • *understand the steps and templates that can assist in the production of reports.*	**Sandy Blake** and **Louise Allsopp**
3:00pm	Implementing and auditing recommendations Building organisational capability in adverse event review process *Participants will:* • *identify how best to use the information learnt in an integrated approach to patient safety* • *explain how change management and quality improvement programmes can enhance patient safety* • *have an opportunity to ask questions about implementing patient safety systems within their organisation*	**Sandy Blake** and **Louise Allsopp**
3:45pm	Poroporoaki	
4:00pm	***Workshop ends***	