HCAC2023

7TH QUALITY HEALTH CARE CONFERENCE AND EXHIBITION

Nov 13th-15th 2023

Globalization Toward Quality & Patient Safety
A Future Perspective

الجودة من منظور عالمي - تطلعات مستقبلية

How to Coproduce Patient Safety

Peter Lachman

Learning objectives

At the end of the workshop you will be able to:

1. Apply safety methods on a day-to-day basis.
2. Develop a safety programme in your own clinical team
3. Identify strategies to implement safe, high quality, and equitable care.
4. Enable staff to become psychologically safe in the workplace.

Programme

Introduction and challenges for safer care
Overview of the theory and methods for safer care
Table work in group to discuss how this can be applied
Stories from teams
Interactive application of the theory methods

Table talk

There will be times to talk at your table

Welcome ice breaker

Introduce your self to your neighbour

Ask each other:

- Why did you come to the session?
- What do you want to learn?

The safety challenge

Prevalence of harm in hospitals

RESEARCH

OPEN ACCESS

Check for updates

Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis

Maria Panagioti,[1] Kanza Khan,[1] Richard N Keers,[2] Aseel Abuzour,[2] Denham Phipps,[2] Evangelos Kontopantelis,[1] Peter Bower,[1] Stephen Campbell,[1] Razaan Haneef,[3] Anthony J Avery,[4] Darren M Ashcroft[1]

[1]NIHR Greater Manchester Patient Safety Translational

ABSTRACT

drugs (25%, 95% confidence interval 16% to 34%)

2019

SPECIAL ARTICLE FREE PREVIEW

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H., Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A., et al.

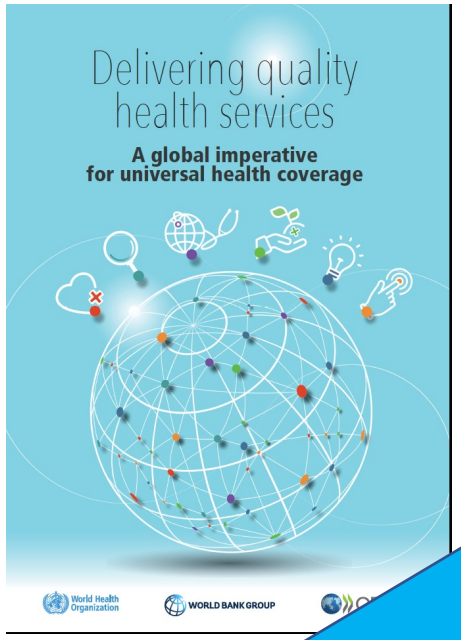
January 12, 2023
N Engl J Med 2023; 388:142-153
DOI: 10.1056/NEJMsa2206117

BACKGROUND Adverse events during hospitalization are a major cause of patient harm, as documented in the 1991 Harvard Medical Practice Study. Patient safety has changed substantially in the decades since that study was conducted, and a more current assessment of harm during hospitalization is warranted.

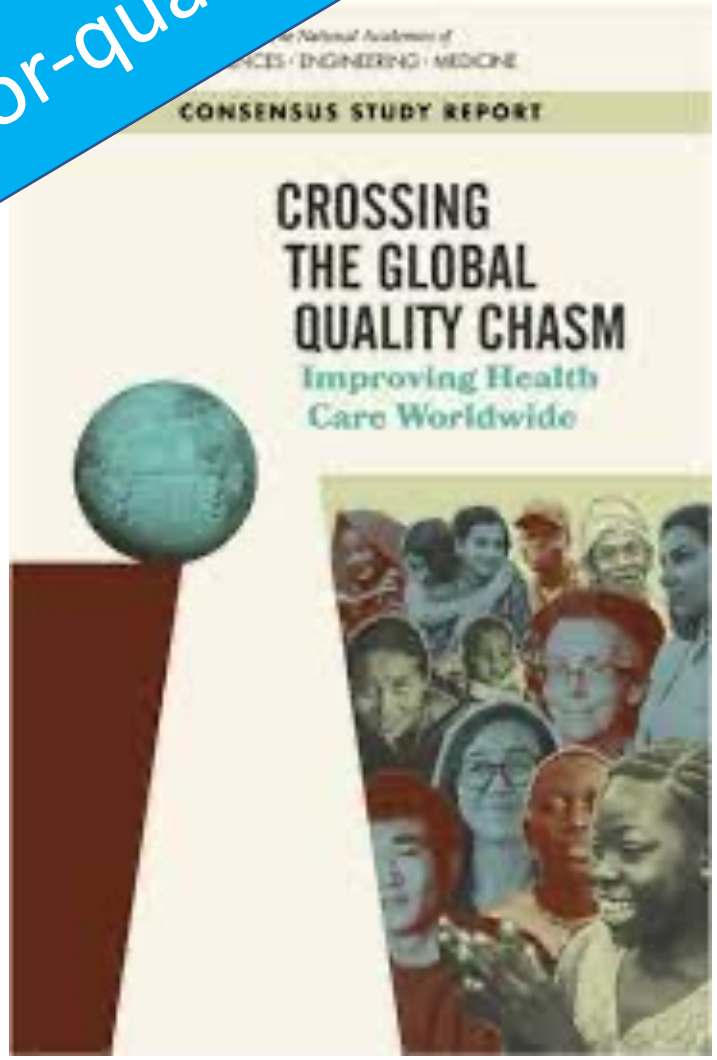
2023

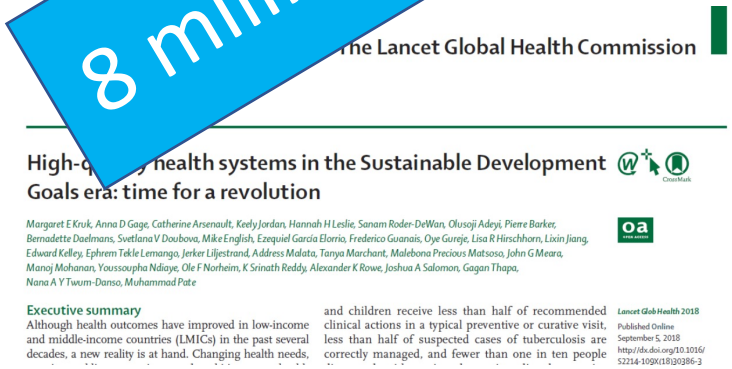
Around one in 20 patients are exposed to preventable harm in medical care

In a random sample of 2809 admissions, we identified at least one adverse event in 23.6%. Among 978 adverse events, 222 (22.7%) were judged to be preventable and 316 (32.3%) had a severity level of seriousness



8 million deaths from unsafe or poor-quality care




The Lancet Global Health Commission

High-q health systems in the Sustainable Development Goals era: time for a revolution

Margaret E Kruk, Anna D Gage, Catherine Arsenault, Keely Jordan, Hannah H Leslie, Sanam Roder-DeWan, Olusoji Adeyi, Pierre Barker, Bernadette Daelmans, Svetlana V Doubova, Mike English, Ezequiel García Elorrio, Frederico Guanais, Oye Gureje, Lisa R Hirschhorn, Lixin Jiang, Edward Kelley, Ephrem Tekle Lemango, Jerker Liljestrand, Address Malata, Tanya Marchant, Malebona Precious Matsoso, John G Meara, Manoj Mohanan, Youssoupha Ndiaye, Ole F Norheim, K Srinath Reddy, Alexander K Rowe, Joshua A Salomon, Gagan Thapa, Nana A Y Twum-Danso, Muhammad Pate

Executive summary

Although health outcomes have improved in low-income and middle-income countries (LMICs) in the past several decades, a new reality is at hand. Changing health needs, and children receive less than half of recommended clinical actions in a typical preventive or curative visit, less than half of suspected cases of tuberculosis are correctly managed, and fewer than one in ten people

Lancet Glob Health 2018
Published Online September 5, 2018
http://dx.doi.org/10.1016/S2214-109X(18)30386-3

Table talk 2

What do you think are top 5 safety challenges?

Jargon

Complex theory

We aim to translate jargon and complex theory into action you can do every day as you hardwire safety into daily work

Challenges for patient safety

Despite knowing what to do we still do not know how to get people to do the right thing

The challenge of implementation

QUALITY OF CARE

By David W. Bates and Hardeep Singh

Two Decades Since *To Err Is Human*: An Assessment Of Progress And Emerging Priorities In Patient Safety

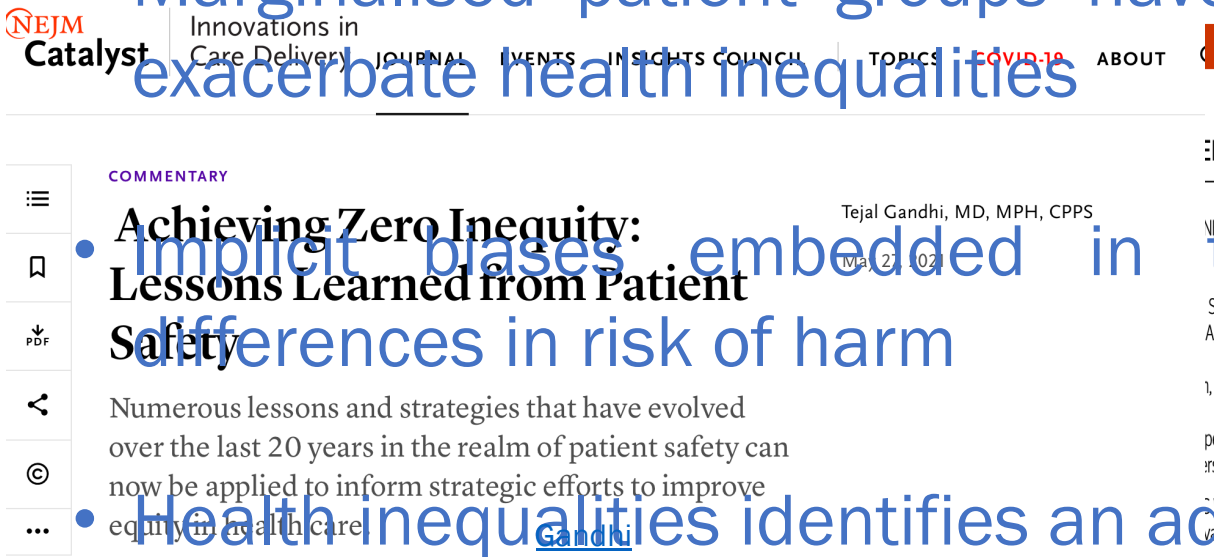
Bates, D. W., & Singh, H. (2018). Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety. *Health affairs (Project Hope)*, *37*(11), 1736–1743. https://doi.org/10.1377/hlthaff.2018.0738

The challenge of inequity

“Health equity means that every person has a fair and just opportunity to be as healthy and safe as possible."

The challenge of inequity

- Marginalised patient groups have more patient safety incidents which exacerbate health inequalities
- Implicit biases embedded in the healthcare system drive these differences in risk of harm
- Health inequalities identifies an additional line of action in patient safety


NEJM Catalyst | Innovations in Care Delivery

JOURNAL EVENTS INSIGHTS COUNCIL TOPICS COVID-19 ABOUT

COMMENTARY

Achieving Zero Inequity: Lessons Learned from Patient Safety

Tejal Gandhi, MD, MPH, CPPS

May 27, 2021

Numerous lessons and strategies that have evolved over the last 20 years in the realm of patient safety can now be applied to inform strategic efforts to improve equity in health care.

Gandhi


ANALYSIS

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EN ACCESS

Action on patient safety can reduce health inequalities

Providers and health systems should use ethnic differences in risk of harm from healthcare to reimagine their role in reducing health inequalities, write **Cian Wade and colleagues**

Cian Wade, [1,2] Akanksha Mimi Malhotra, [3] Priscilla McGuire, [1] Charles Vincent, [4] Aidan Fowler [1]

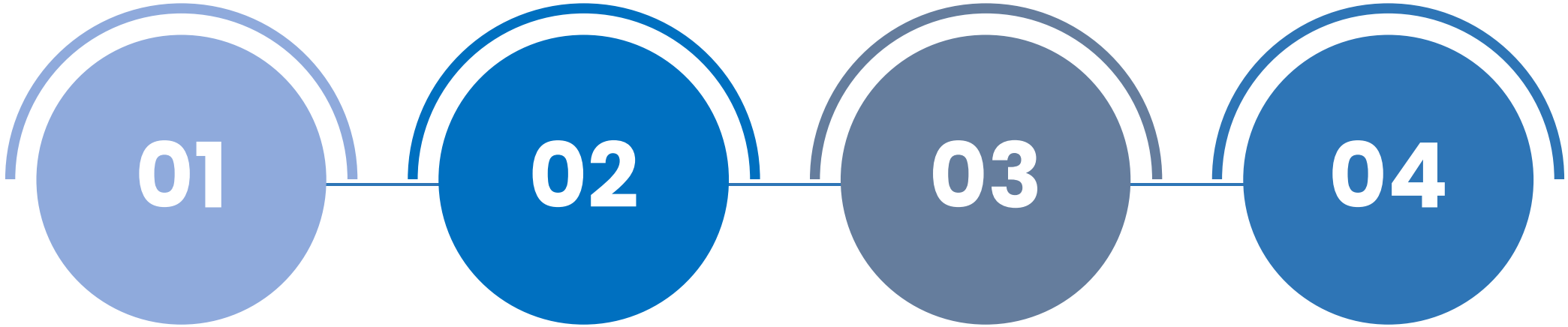
Health inequalities are widening in many high income countries and have been thrown into focus by the covid-19 pandemic. [1-4] Not only have black, Hispanic, Asian, and other marginalised ethnic

- General harms: dehydration, falls, hospital acquired infection, delayed detection and response to clinical deterioration

Wade et al

Lived experience of healthcare workers

Impact of alienation



Powerlessness

Lack of meaning and sense of belonging

Estrangement and isolation

Normlessness

Dukheim, Marx and Weber

Impact of burnout on patient safety 2023

Physicians with burnout are twice as likely to be involved in patient safety incidents and show low professionalism, and over twice as likely to receive low satisfaction ratings from patients.

OPEN ACCESS

Check for updates

Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis

Alexander Hodkinson,[1,9] Anli Zhou,[1] Judith Johnson,[2,3] Keith Geraghty,[1] Ruth Riley,[4] Andrew Zhou,[5] Efharis Panagopoulou,[6] Carolyn A Chew-Graham,[7] David Peters,[8] Aneez Esmail,[1] Maria Panagioti[1,9]

For numbered affiliations see end of the article

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Additional material is published online only. To view please visit

ABSTRACT

OBJECTIVE

To examine the association of physician burnout with the career engagement and the quality of patient care globally.

DESIGN

Systematic review and meta-analysis.

heterogeneity, and meta-regressions assessed for potential moderators with significance set using a conservative level of P<0.10.

RESULTS

4732 articles were identified, of which 170 observational studies of 239 246 physicians were included in the meta-analysis. Overall burnout in

170 observational studies with 239246 physicians

The challenge of culture

REVIEW ARTICLE

The Relationship Between Patient Safety Culture and Patient Outcomes: A Systematic Review

Margaret Hardt DiCuccio, RN, MSN

Context: In the past 13 years since the Institute of Medicine report, *To Err is Human*, was published, considerable attention was placed on the relationship between patient safety culture and patient outcomes.

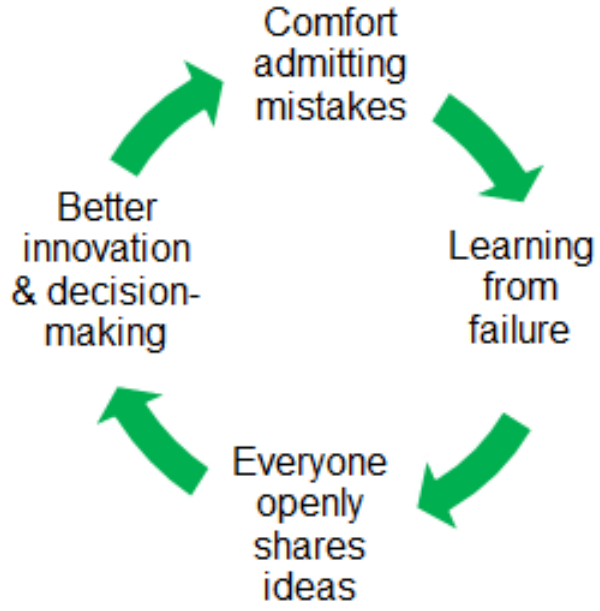
they do not feel safe and culturally supported to speak up when a patient is at risk.[2]

Since the time of the original IOM report, there has been

DiCuccio, M. H. (2015). The Relationship Between Patient Safety Culture and Patient Outcomes: A Systematic Review. *Journal of Patient Safety*, *11*(3), 135–142. https://www.jstor.org/stable/26633090

Psychological Danger

Psychological Safety



The challenge of a patient safety learning system

- fear that they would be blamed for the problem
- fear that they would be punished for breaking laws
- fear that reporting problems doesn't improve patients' safety
- lack of support in the organization
- lack of feedback
- lack of knowledge about reporting systems
- No clear guidelines on what errors should be reported.

Health Quality Ontario

Let's make our health system healthier

ONTARIO HEALTH TECHNOLOGY ASSESSMENT SERIES

Patient Safety Learning Systems: A Systematic Review and Qualitative Synthesis

Health Quality Ontario. Patient Safety Learning Systems: A Systematic Review and Qualitative Synthesis. Ont Health Technol Assess Ser [Internet]. 2017 Mar;17(3):1-23. Available from: http://www.hqontario.ca/Evidence-to-Improve-Care/Journal-Ontario-Health-Technology- Assessment-Series

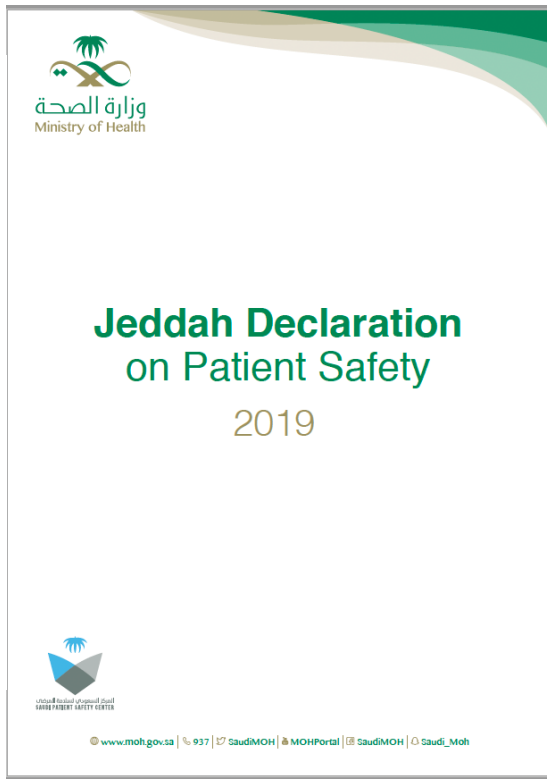
The challenge of translating policy to action

Third Global Ministerial Summit on Patient Safety, 14 April 2018, Tokyo, Japan

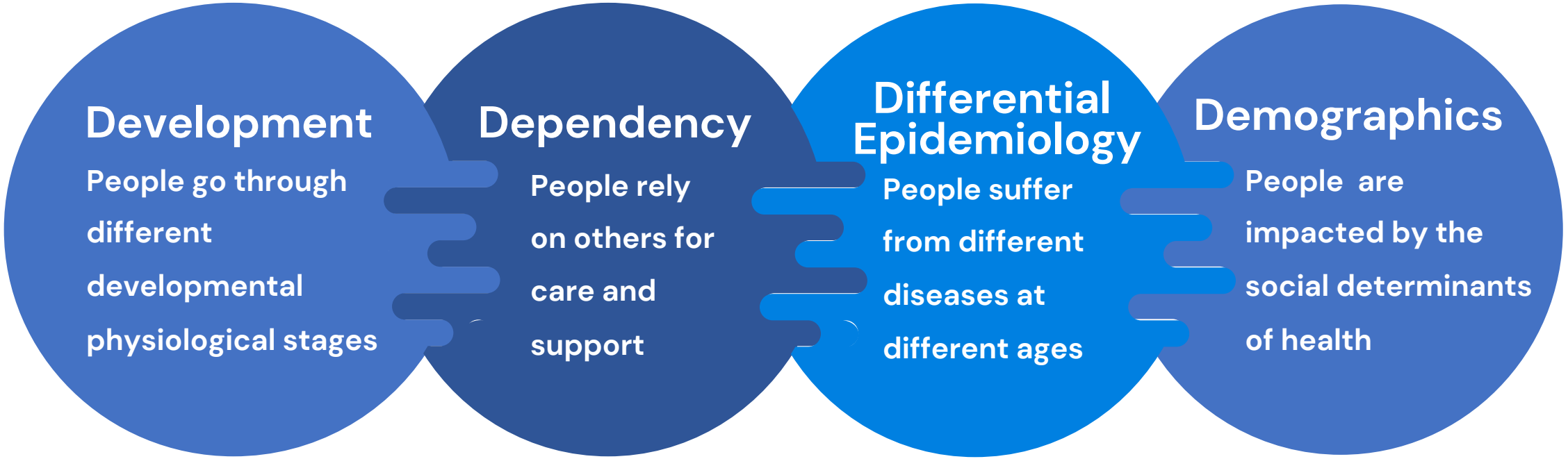
Tokyo Declaration on Patient Safety

(Finalised Draft)

Declaration put forward by Japan, Germany, and the United Kingdom of Great Britain and Northern Ireland, and endorsed by (Australia, Brunei Darussalam, Croatia, Czech Republic, Denmark, Finland, France, Greece, Indonesia, Lithuania, Luxembourg, Mongolia, Oman, Poland, Qatar, South Africa, Slovakia, Sri Lanka, Switzerland, Vietnam, Asian Development Bank Institute, Japan International Cooperation Agency, World Bank Group, World Health Organization, Patient Safety Movement Foundation, and World Medical Association)



The challenge of People as Patients



Adapted from, Woods D, Thomas E, Holl J, Altman S, Brennan T. Adverse events an preventable adverse events in children. Pediatrics. 2005;115(1):155–160

The challenge of lack of knowledge

Pediatric he
environments
working knov

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

2019

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Principles of Pediatric Patient Safety: Reducing Harm Due to Medical Care

Brigitta U. Mueller, MD, MHCM, CPPS, CPHQ, FAAP,[a,b] Daniel Robert Neuspiel, MD, MPH, FAAP,[c] Erin R. Stucky Fisher, MD, FAAP,[d]
COUNCIL ON QUALITY IMPROVEMENT AND PATIENT SAFETY, COMMITTEE ON HOSPITAL CARE

all practice
having a
nguage.

Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety.*
IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

The challenge of lack of leadership for safety

- Step One: Address Strategic Priorities, Culture, and Infrastructure
- Step Two: Engage Key Stakeholders
- Step Three: Communicate and Build Awareness
- Step Four: Establish, Oversee, and Communicate System-Level Aims
- Step Five: Track/Measure Performance Over Time, Strengthen Analysis
- Step Six: Support Staff and Patients/Families Impacted by Medical Errors
- Step Seven: Align System-Wide Activities and Incentives
- Step Eight: Redesign Systems and Improve Reliability

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Innovation Series 2006

Leadership Guide to Patient Safety

2006

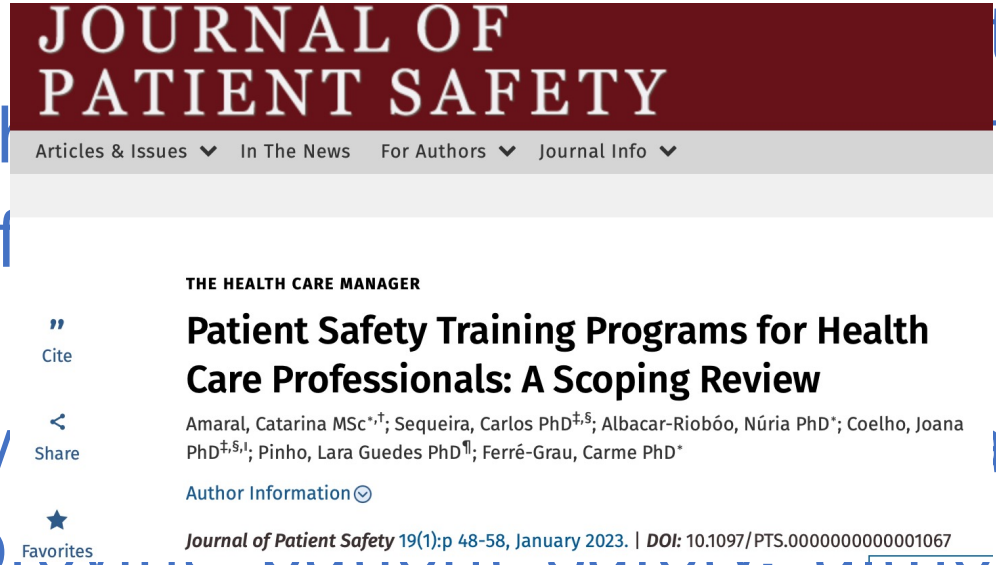
Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety.* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006. (Available or

The challenge of lack of education

Variable evidence on efficacy of training 2023

"There are still tient safety training programs, whic the importance of implementing saf

The existing ev acy of the training programs in imp ough there are some gaps."



Amaral, C., et al (2023). Patient Safety Training Programs for Health Care Professionals: A Scoping Review. Journal of patient safety, 19(1), 48–58. https://doi.org/10.1097/PTS.0000000000001067

The challenge of technology

Design

Implementation and use safely

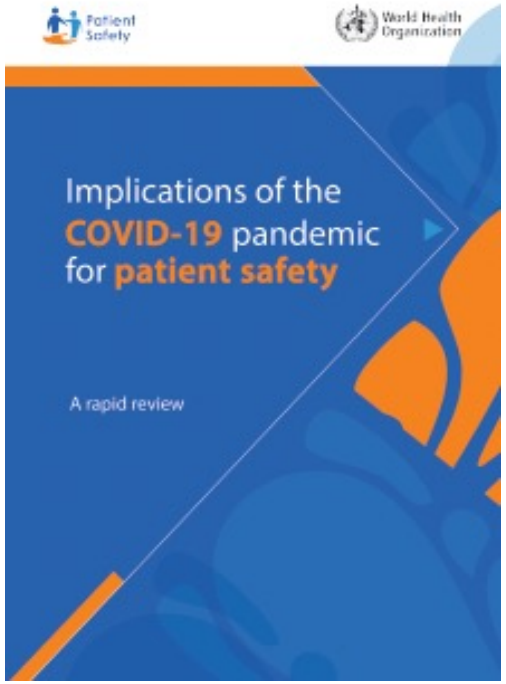
Monitor

Control outcomes

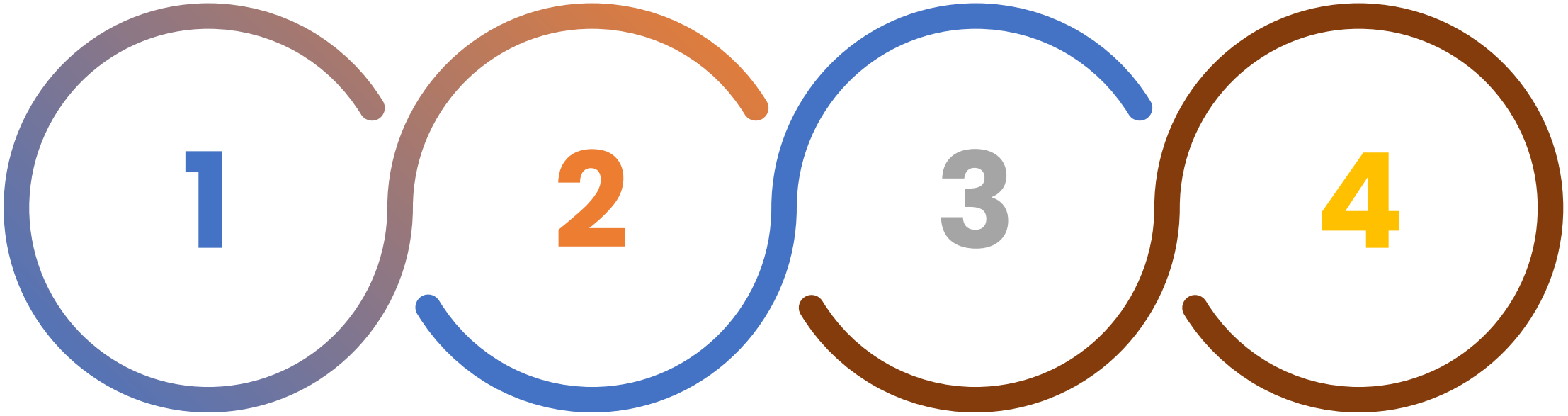
Sittig, D. F., Wright, A., Coiera, E., Magrabi, F., Ratwani, R., Bates, D. W., & Singh, H. (2020). Current challenges in health information technology-related patient safety. *Health informatics journal*, *26*(1), 181–189. https://doi.org/10.1177/1460458218814893

The challenge of COVID

- Safety gaps
- Disruption to processes
- Capacity affected
- Managing covid difficult in fragile states
- Misinformation
- Healthcare worker safety compromised
- Person centred care impacted
- Safety and equity
- Some positives e.g. vaccination and telemedicine



Challenges and context



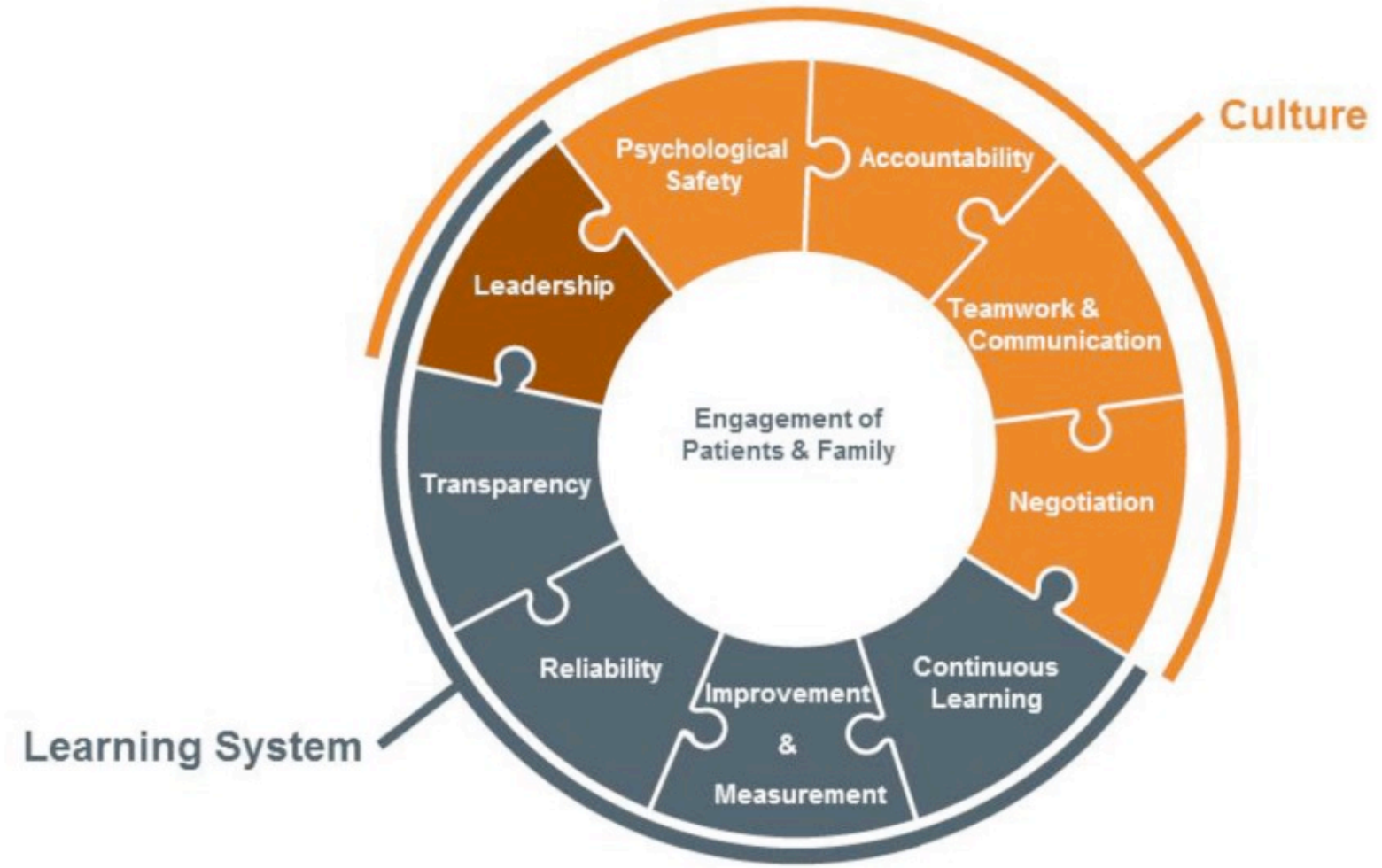
All are the context

Table talk 3

What is your greatest challenge?

To deal with these challenges we need to think differently

Figure 1. Framework for Safe, Reliable, and Effective Care



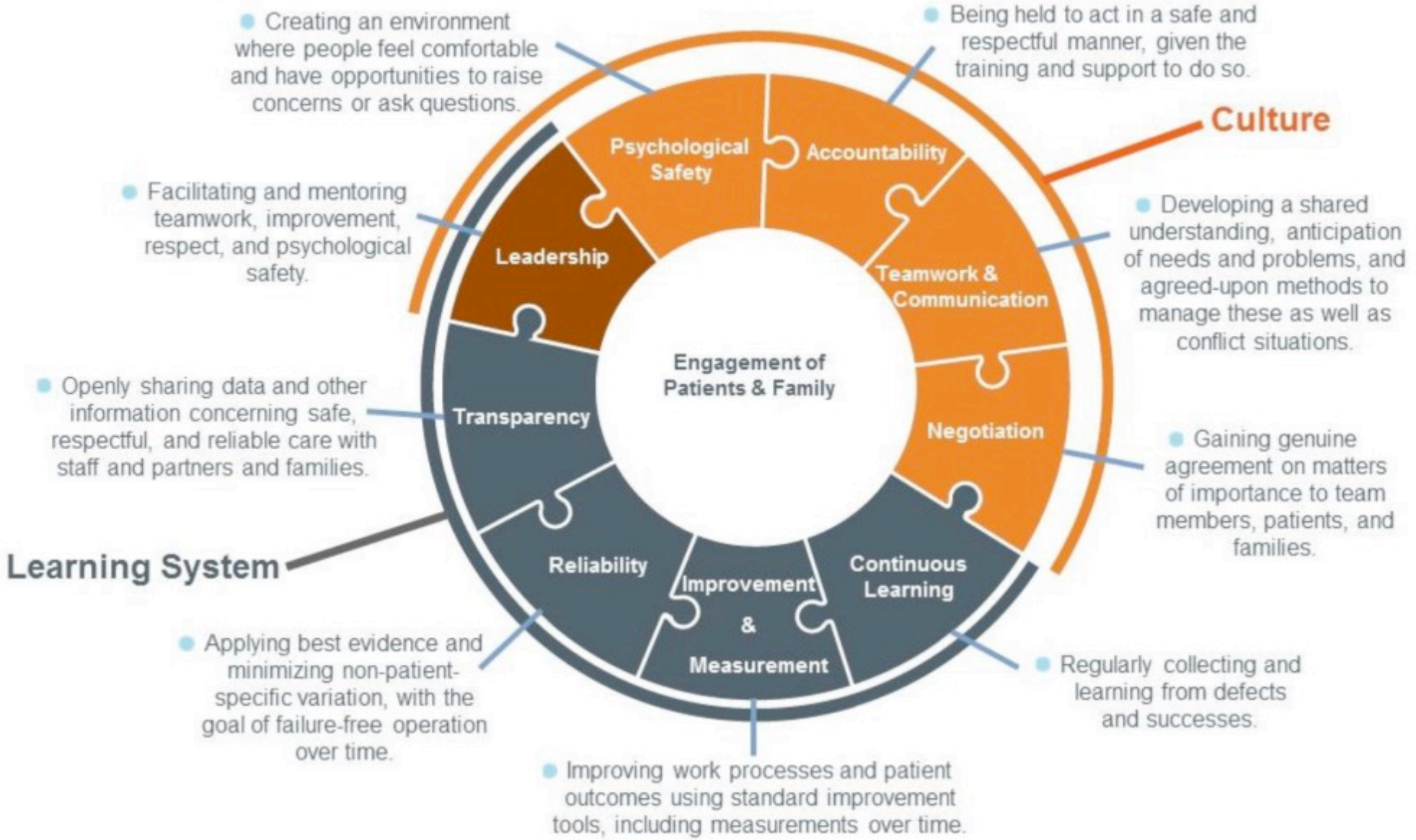
Institute for Healthcare Improvement

SAFE & RELIABLE Healthcare

WHITE PAPER

A Framework for Safe, Reliable, and Effective Care

Figure 2. Framework for Safe, Reliable, and Effective Care — with Descriptive Detail for the Components



Zero harm is a state of mind

Who must think differently?

People

or persons

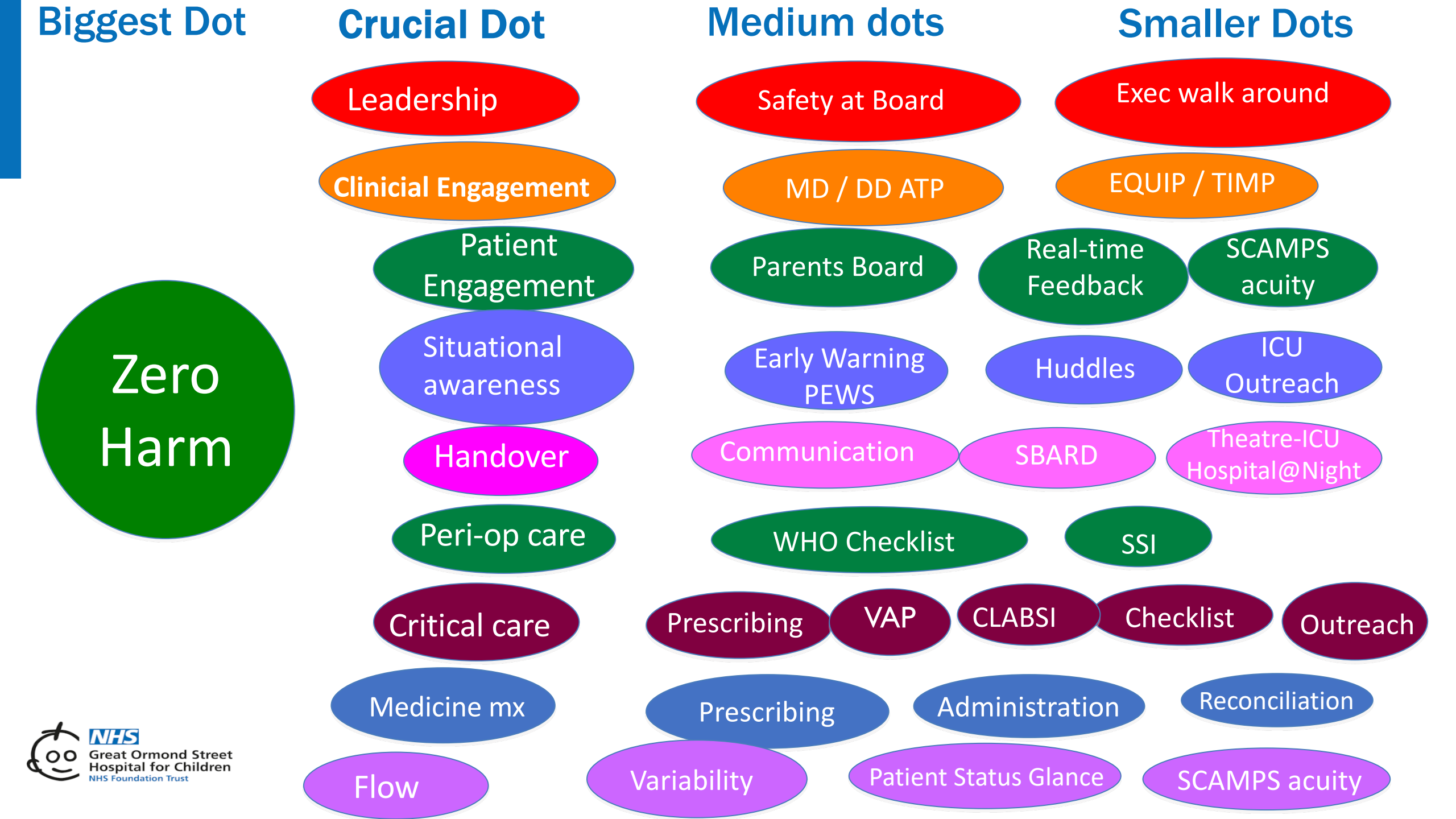
we call patients and families

People

or persons

we call healthcare providers

Vision in 2006


Biggest Dot
Crucial Dot
Medium dots
Smaller Dots
Zero Harm
Leadership
Clinicial Engagement
Patient Engagement
Situational awareness
Handover
Peri-op care
Critical care
Medicine mx
Flow
Safety at Board
MD / DD ATP
Parents Board
Early Warning PEWS
Communication
SBARD
Theatre-ICU Hospital@Night
WHO Checklist
SSI
Prescribing
VAP
CLABSI
Checklist
Outreach
Prescribing
Administration
Reconciliation
Variability
Patient Status Glance
SCAMPS acuity
Exec walk around
EQUIP / TIMP
Real-time Feedback
SCAMPS acuity
Huddles
ICU Outreach
NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

World Health Global Action Plan

The **action** plan aims to provide Member States and other stakeholders with an **action**-oriented framework to facilitate the implementation of strategic **patient safety** interventions at all levels of **health systems** globally over the next 10 years (2021–2030)

Strategic Objective 1

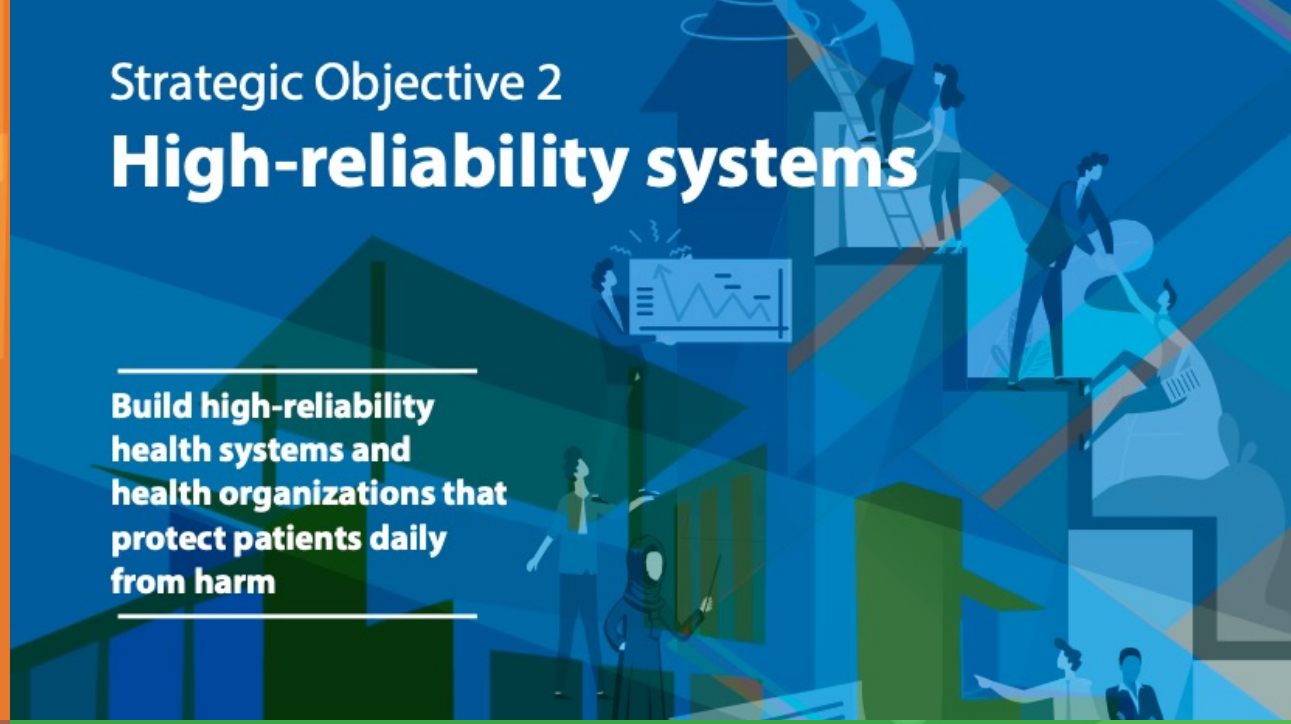
Policies to eliminate avoidable harm in health care

Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere

Strategic Objective 2

High-reliability systems

Build high-reliability health systems and health organizations that protect patients daily from harm



Strategic Objective 6

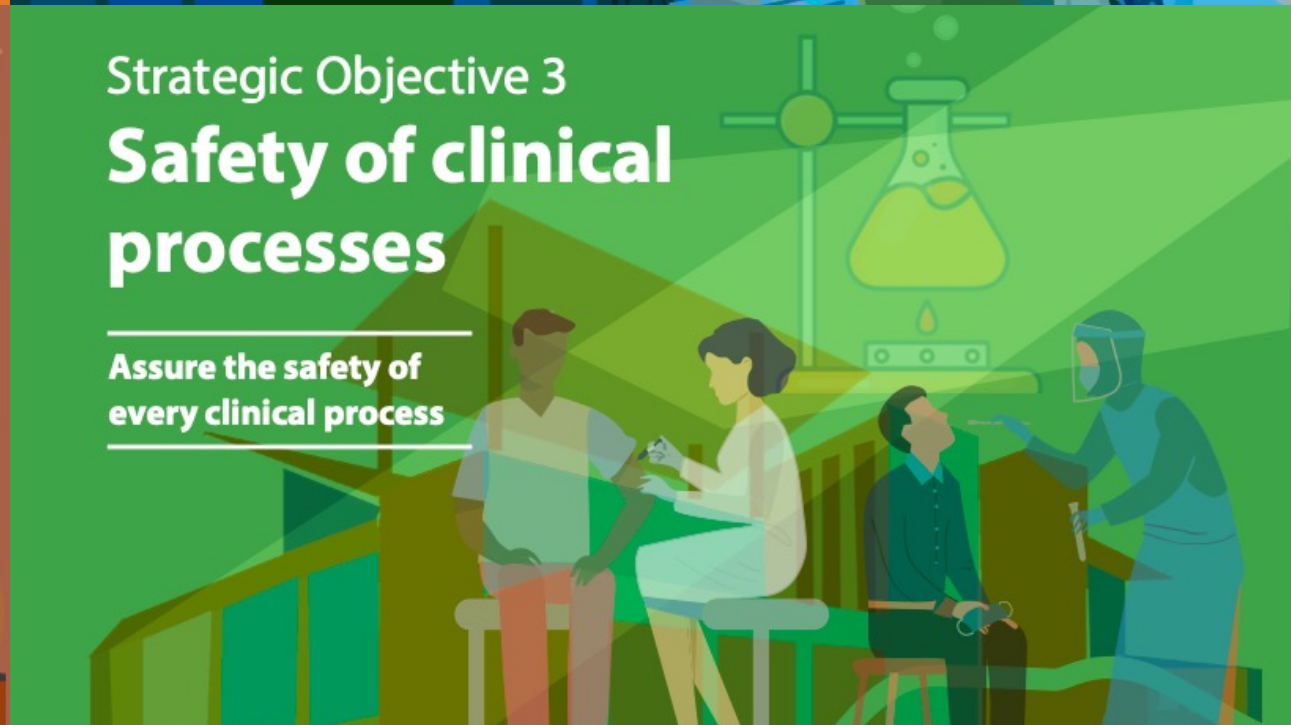
Information, research and risk management

Ensure a constant flow of information and knowledge to drive the mitigation of risk, a reduction in levels of avoidable harm, and improvements in the safety of care

Strategic Objective 3

Safety of clinical processes

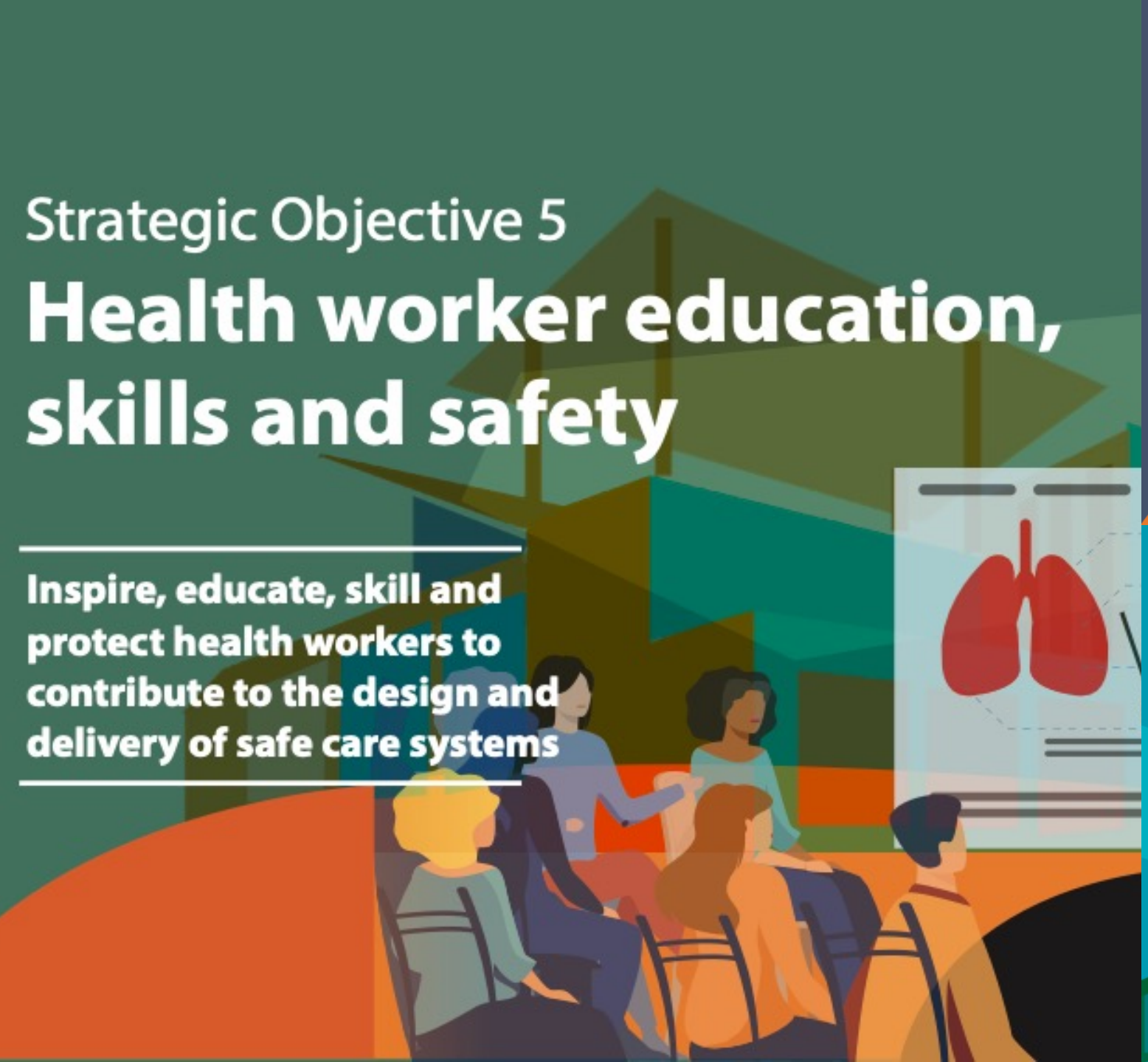
Assure the safety of every clinical process



Strategic Objective 5

Health worker education, skills and safety

Inspire, educate, skill and protect health workers to contribute to the design and delivery of safe care systems



Strategic Objective 7

Synergy, partnership and solidarity

Develop and sustain multisectoral and multinational synergy, partnership and solidarity to improve patient safety and quality of care

Strategic Objective 4

Patient and family engagement

Engage and empower patients and families to help and support the journey to safer health care

S.A.F.E®

Situation Awareness for Everyone

"Safety is the ability of a system to sustain required operations under both expected and unexpected conditions. Safety is what we do every day."

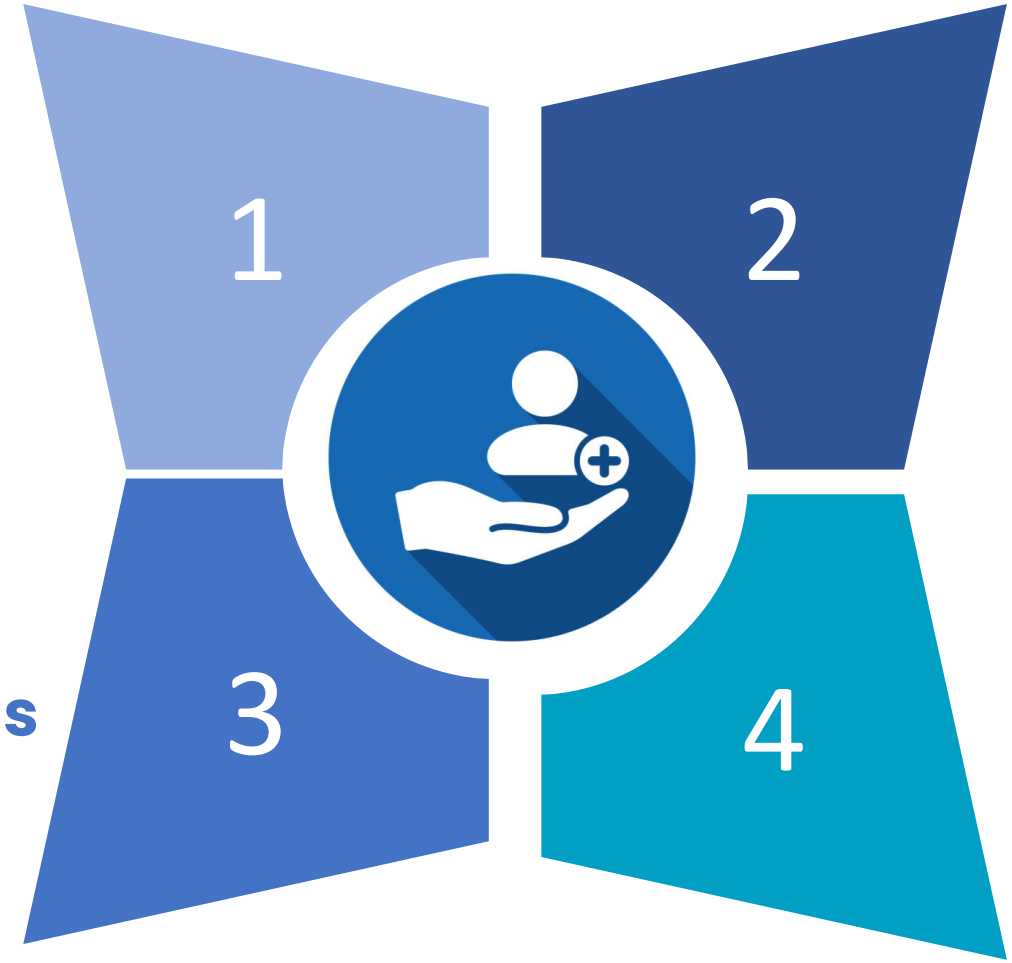
Erik Hollnagel

What theory is used in S.A.F.E.?

The foundation of safe and high quality care

Epidemiology and Measurement

Patient Safety theory and methods



Leadership Culture and Values

Improvement and Implementation Science

The safer care and quality journey

Lead and develop a culture of safety

People must have psychological safety and address impact of industrialization

Recognise Define and measure

Accept there if a problem to be addressed

Design care for safety

Include human factors and reliability theory and resilience

Enhance processes for safety

Study safety every day and respond to technology

Learn

Create a learning environment

Adapted from Liberati et al. 2020

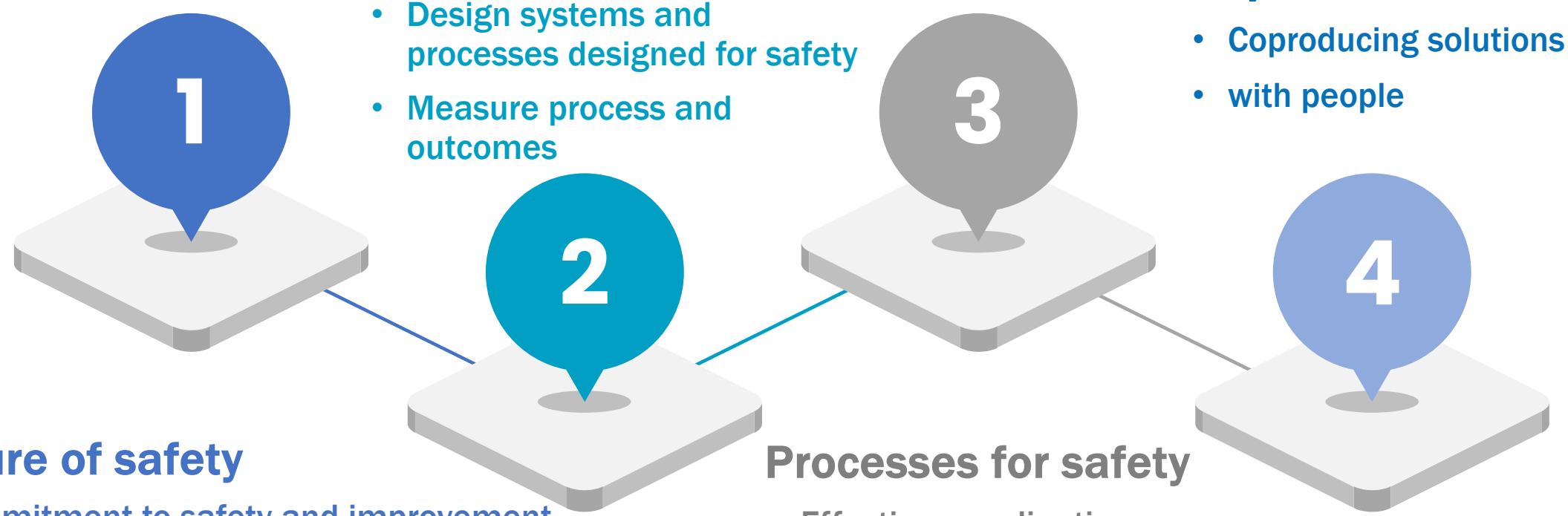
Four features of safer care

Design for safety

- Design systems and processes designed for safety
- Measure process and outcomes

Coproduce for safety

- Coproducing solutions
- with people



Culture of safety

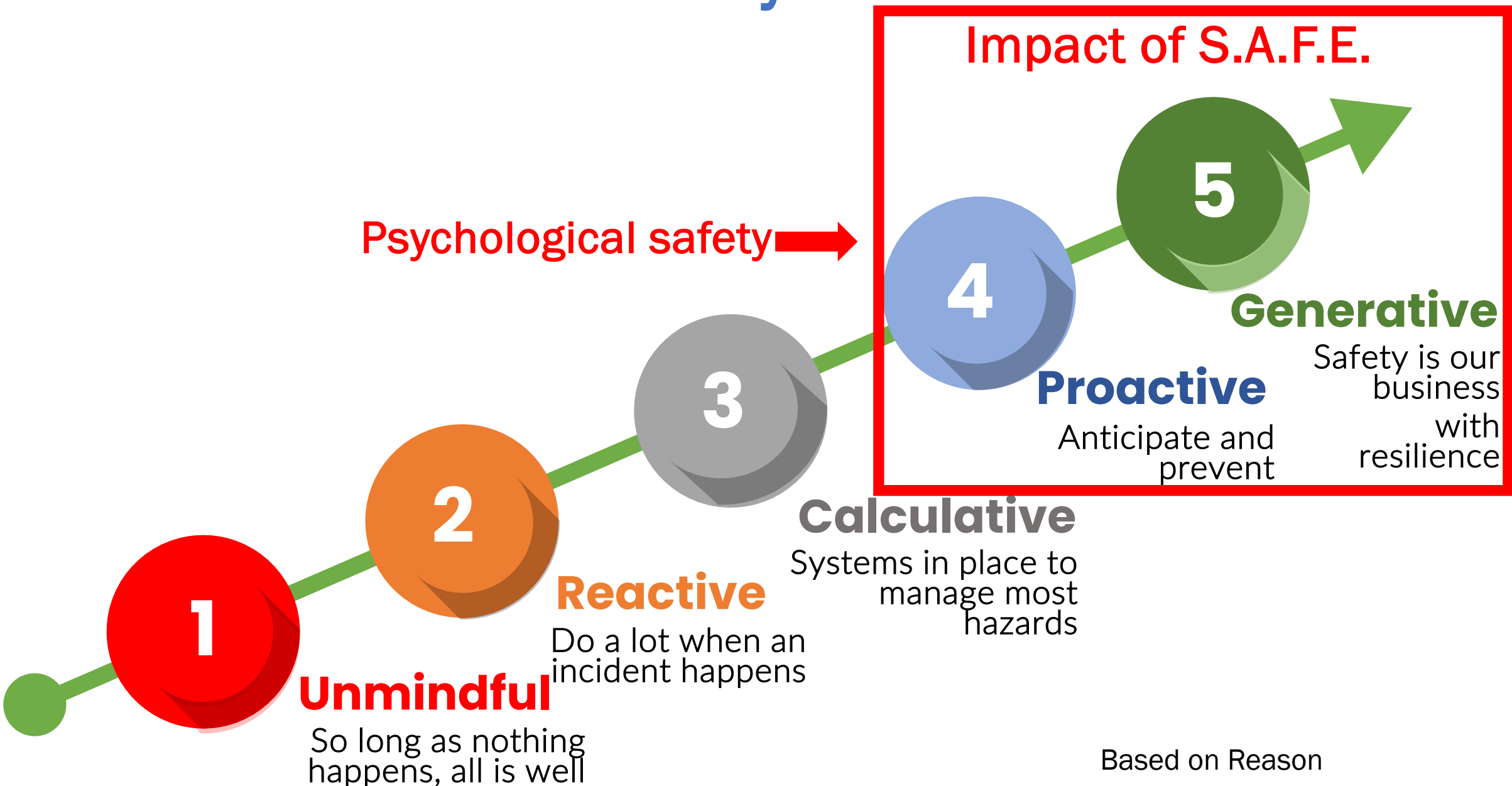
- Commitment to safety and improvement with everyone involved
- Teamwork, cooperation and positive working relationships
- Constant reinforcement of safe, ethical, respectful behaviours

Processes for safety

- Effective coordination
- Ability to mobilize quickly
- Technical competence, supported by formal training and informal learning;
- Problem-sensing systems as basis of action

Adapted from Liberati et al. 2020

Enhance a Culture of Safety



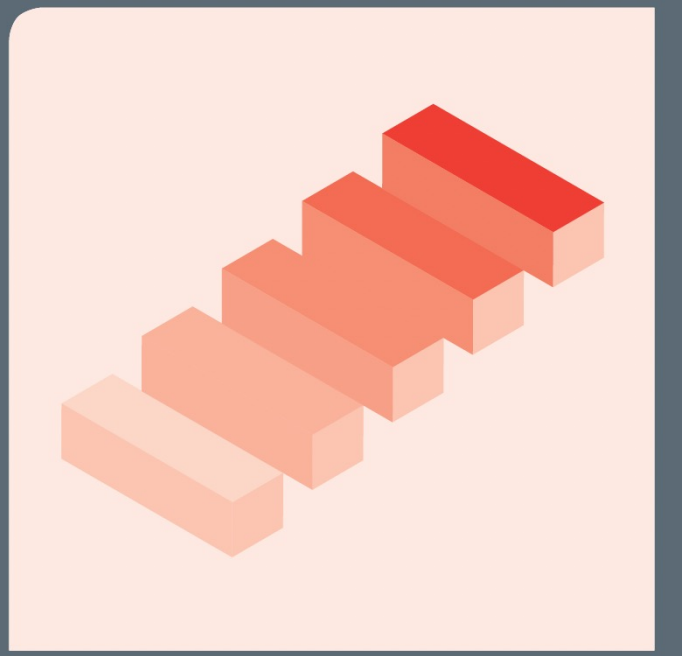
Based on Reason

Manchester Patient Safety MaPSaF

MANCHESTER 1824
The University of Manchester

NHS
National Patient Safety Agency

Manchester Patient Safety Framework (MaPSaF)
Acute



How to use MaPSaF

MaPSaF is best used as a team based self-reflection and educational exercise:

- it should be used by all appropriate members of your team;
- for each of the ten aspects of safety culture, select the description that you think best fits your organisation and/or team.
  Do this individually and privately, without discussion;
- use a T (team) or O (organisation) on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current patient safety culture profile for your organisation;
- discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus;
- consider the overall picture of your organisation and/or team. You will almost certainly notice that the emerging profile is not uniform – that there will be areas where your organisation is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your organisation not more like that? How can you move forward to a higher level?

What we mean by these terms

Patient safety incident (PSI):	Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded healthcare.
Prevented patient safety incident (PPSI):	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare.
Root cause analysis (RCA):	A technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. Retrospective and multidisciplinary in its approach, it is designed to identify the sequence of events, working back from the incident.

Evaluation sheet (sample)

Dimension of patient safety culture	A	B	C	D	E
1. Commitment to overall continuous improvement					
2. Priority given to safety					
3. System errors and individual responsibility					
4. Recording incidents and best practice					
5. Evaluating incidents and best practice					
6. Learning and effecting change					
7. Communication about safety issues					
8. Personnel management and safety issues					
9. Staff education and training					
10. Team working					

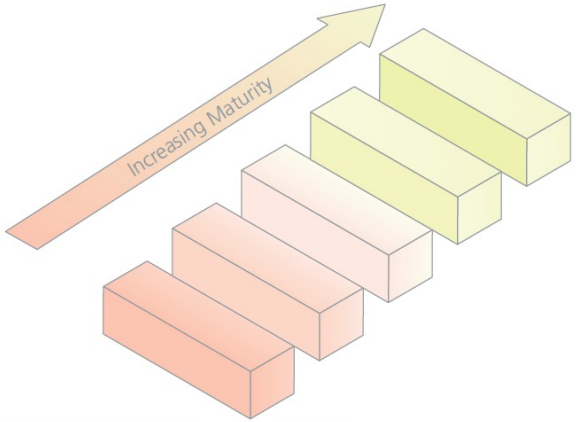
T = Team O = Organisation

Public and patient involvement

It might seem that patient and public involvement in a maturing patient safety culture should be included as a eleventh dimension. However, the development of processes to ensure meaningful participation should be seen as being integral to all ten dimensions identified and this is how they have been integrated into the MaPSaF matrix.

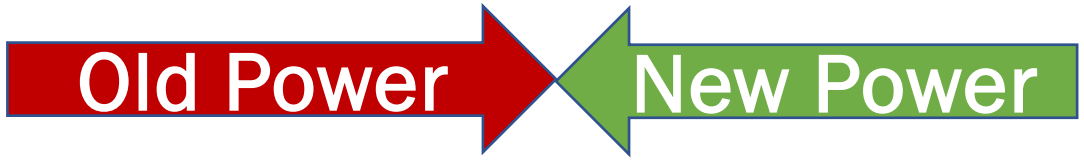
The levels of patient safety culture explained

Level	Description
A – Pathological	Why do we need to waste our time on patient safety issues?
B – Reactive	We take patient safety seriously and do something when we have an incident.
C – Bureaucratic	We have systems in place to manage patient safety.
D – Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E – Generative	Managing patient safety is an integral part of everything we do.



MaPSaF is based on Parker and Hudson's (2001) application of Westrum's (1992) stage model of organisational culture maturity

References
Parker, D and Hudson, P (2001) *Understanding your culture*, Shell International Exploration and Production.
Westrum, R (1992) *Cultures with Requisite Imagination* in Wise, J, Hopkin, D and Stager, P (eds.), *Verification and validation of complex systems: human factors issues* (pp 401–416), Berlin: Springer-Verlag.



Old Power	New Power
Like Currency $	Like a Current
Held by a few	Held by many
Pushed down	Pulled in
Commanded	Shared
Closed	Open
Transaction	Relationship

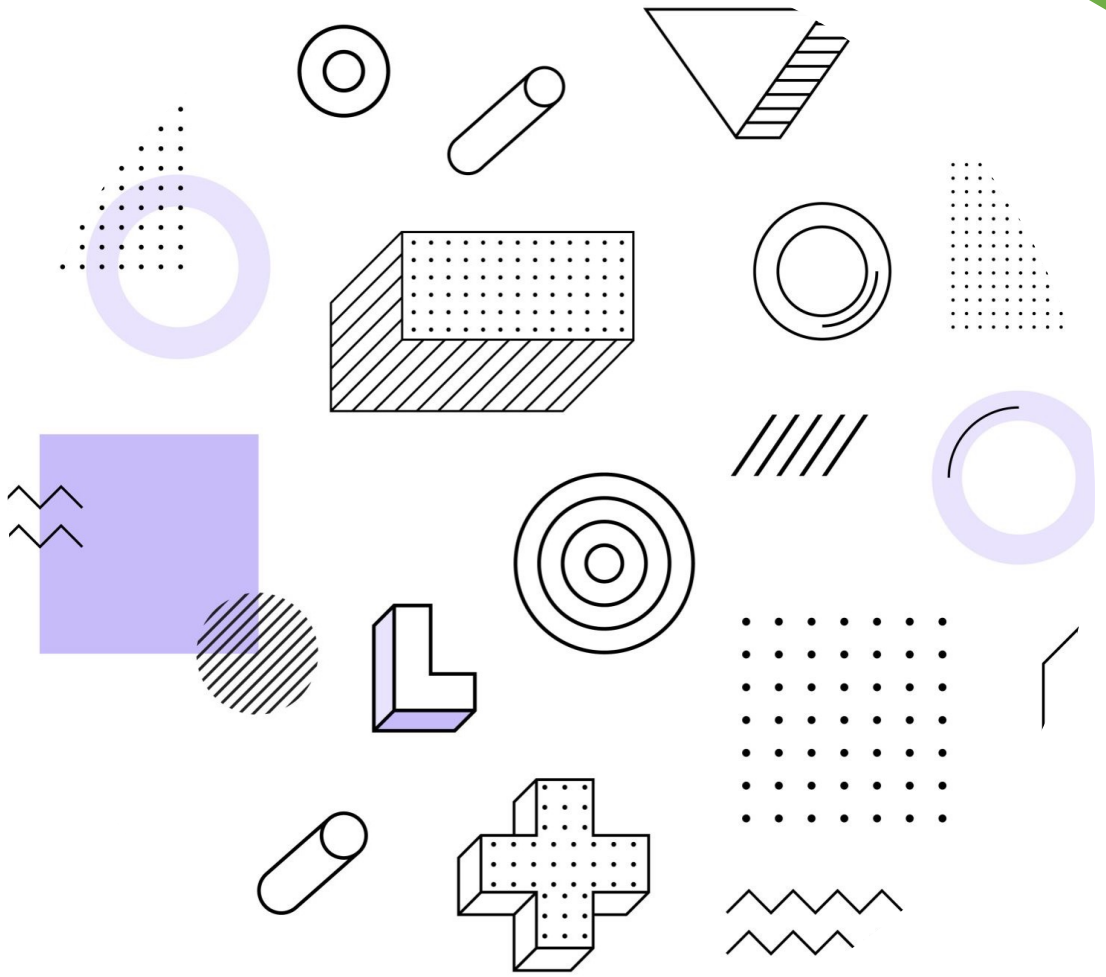
School for change agents

Ensure Values for safety to create value

- Respect each other as a person
- Develop person psychological safety
- Educate people for Safety
- Lead people for safety
- Integrate the people's care to be safer
- Protect healthcare workers as persons
- Coproduce safety with Patients as persons
- Always be transparent
- Develop learning systems
- Be kind to people
- Be humble and learn


Reaction
Anticipation
Proactive
Risk
Management

A proactive and resilient safety system



What is in the S.A.F.E. toolkit?

Activating the Vincent Model for safer healthcare

Improvement of processes and systems

Resilience

Risk control
Mitigation

Monitoring, adaptation and response (resilience)

Aspire to standards safety as best practice

Human Factors

S.A.F.E Situation Awareness for Everyone

The Health Foundation Inspiring Improvement

What did we do well?

Focus on what works

- Focus is on what goes right.
- Use that to understand normal performance, to do better and to be safer.
- Learning uses most of the data available

10-4 := 9.999 non- failures
in 10.000 events

0-4 := 1 failure in 10.000 events

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net

Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Resilience and Safety II

"The variability that completed the job safely on one day is the same variability blamed for the accident on the next."

Hollnagel

The human face of safety

The power of Positive Deviance

Table talk 4

What do you do well?

Have we harmed anyone?

Main areas for harm

- Medication error (especially dosing errors and administration)
- Failure to recognise deterioration
- Failure to recognise sepsis and life-threatening illness
- Hospital acquired infections (e.g., central line infections)
- Preventable pain and distress
- Impact of technology

Adapted from Fitzsimons, J., & Vaughan, D. (2015). Top 10 Interventions in Paediatric Patient Safety. *Current Treatment Options in Pediatrics*, *1*(4), 275-285.

Understanding and mitigating risk

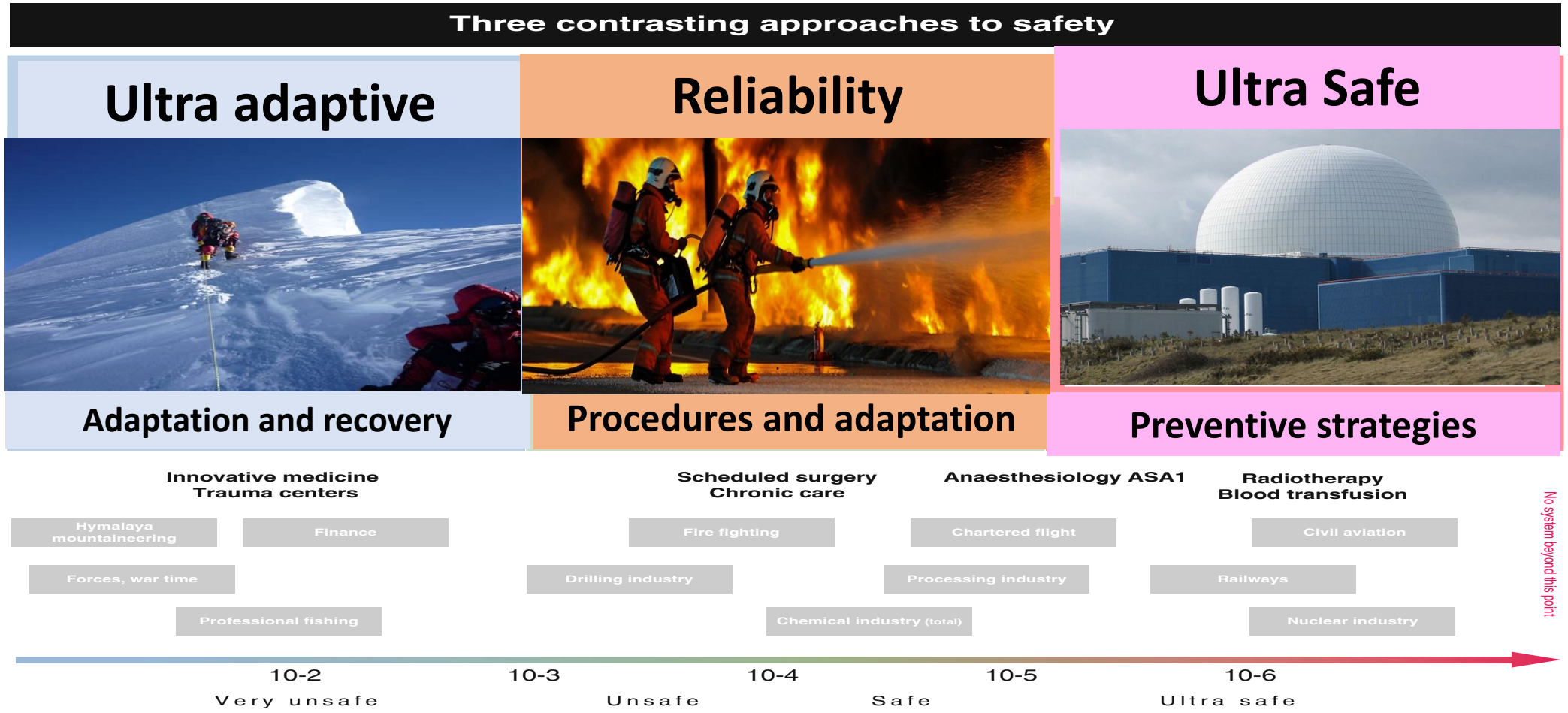


Fig. 3.1 Three contrasting approaches to safety

Adapted from
Safer Healthcare Strategies for the Real World
Charles Vincent Rene Amalberti

Table Talk 5

What are the common harms where you work?

Are doing what we are supposed to do …reliably?

Aim for High Reliability

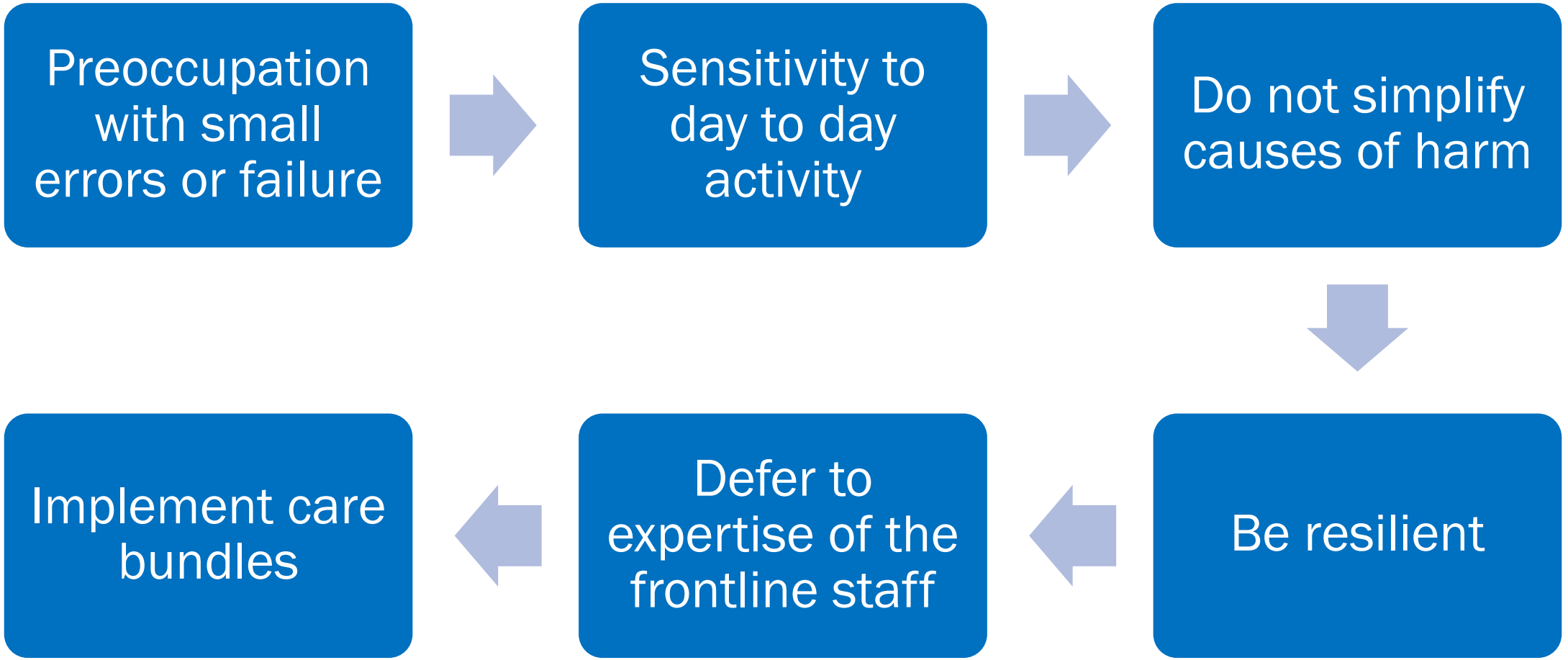


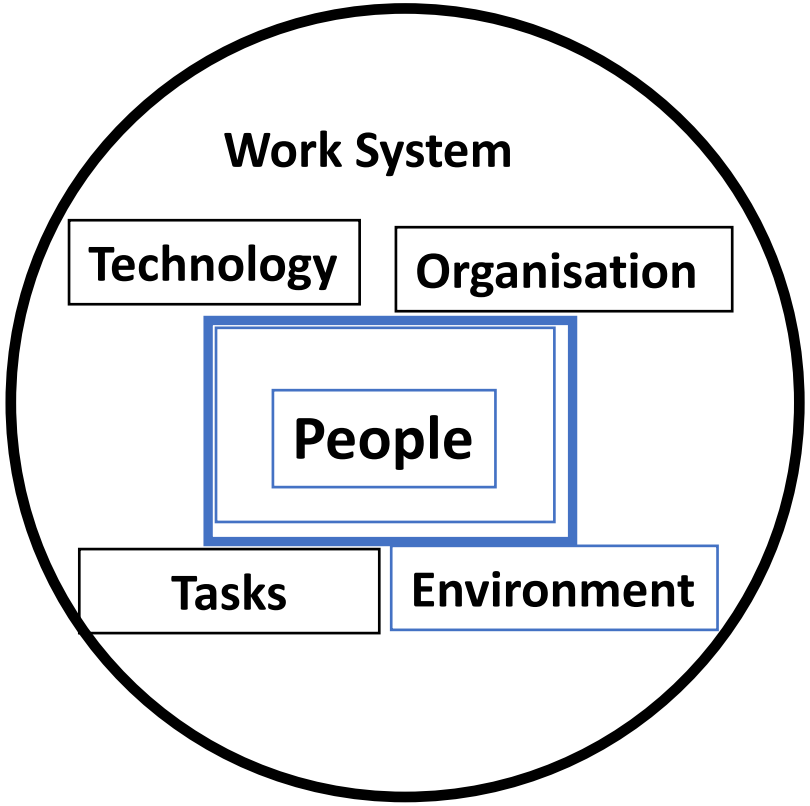
Table talk 6

What do you do reliably?

Are we safe now?

Systems and human factors

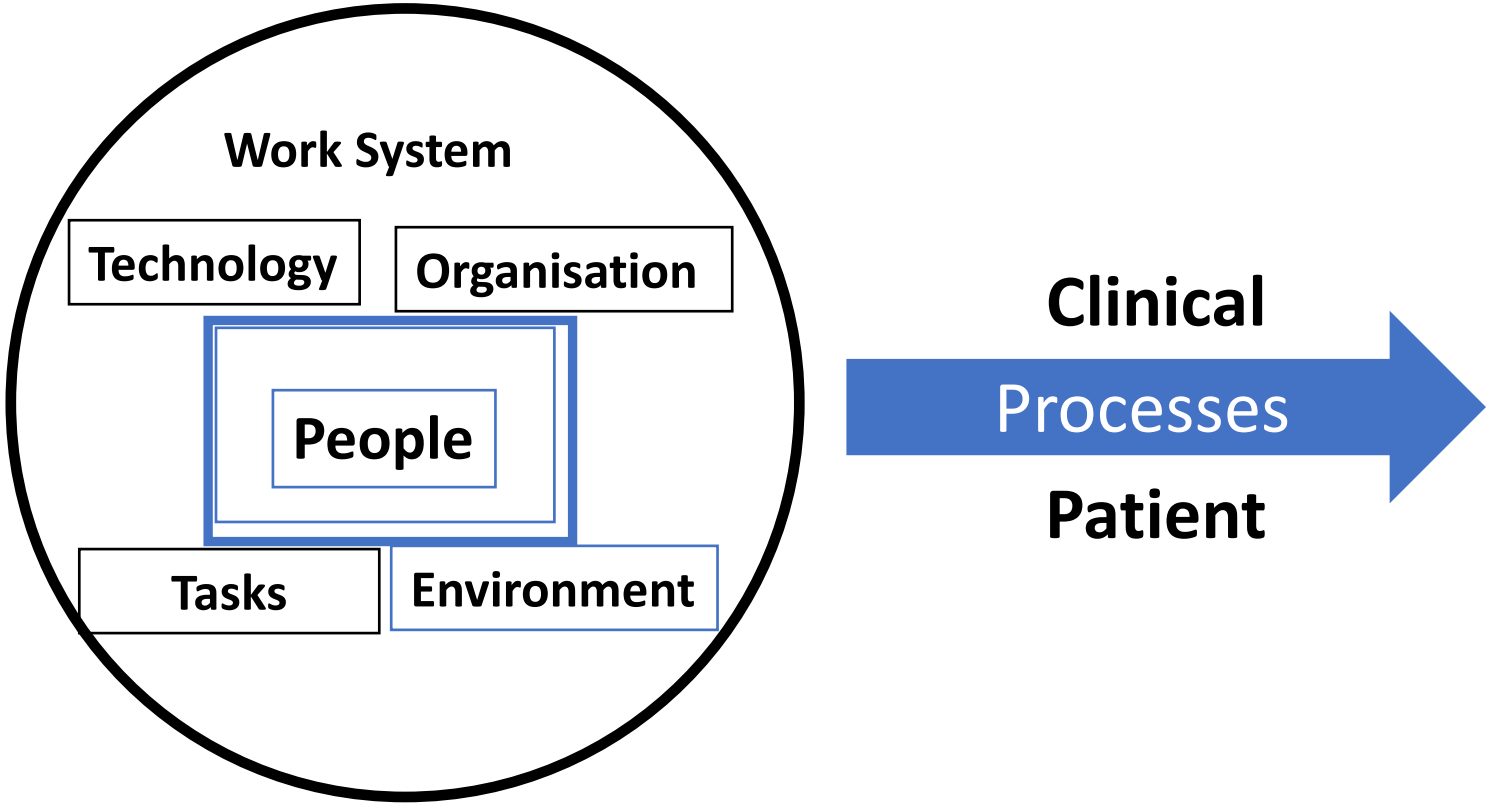
Holden RJ, et al. SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics. 2013;56(11):1669-86. doi: 10.1080/00140139.2013.838643.



Systems + **Process** = **Outcome**

Systems and human factors

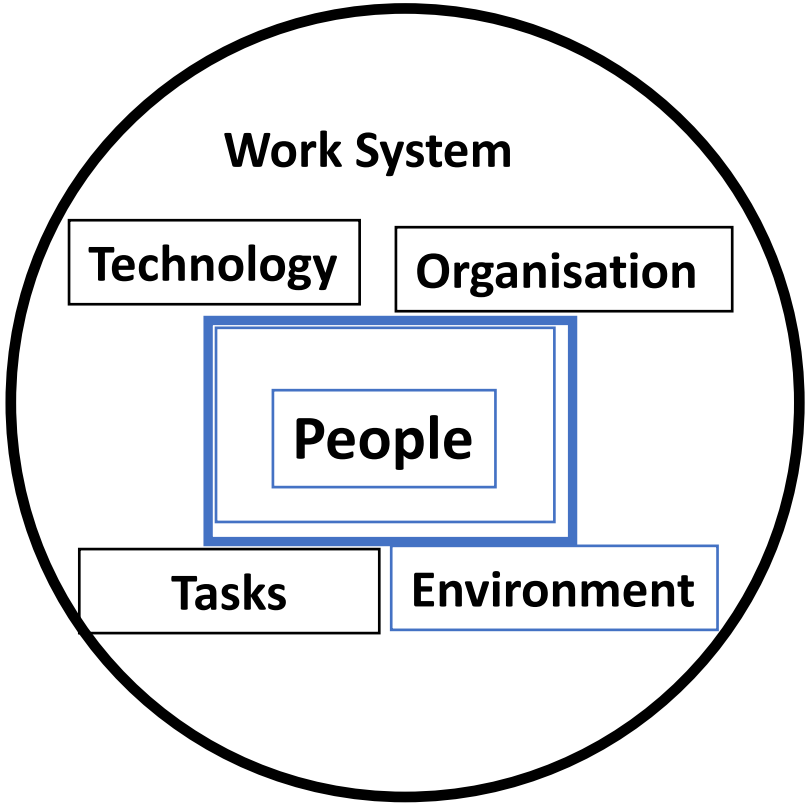
Holden RJ, et al. SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics. 2013;56(11):1669-86. doi: 10.1080/00140139.2013.838643.



Systems + Process = Outcome

Systems and human factors

Holden RJ, et al. SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics. 2013;56(11):1669-86. doi: 10.1080/00140139.2013.838643.



Clinical

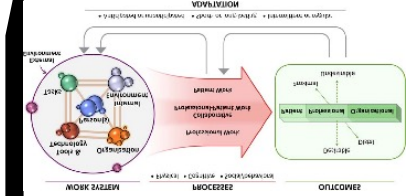
Processes

Patient

Desired outcome

Patient /Organisation /Professional

Undesired outcome



Systems + Process = Outcome

Table talk 7

What does your work system look like?

Will be safe in the future?

Proactive Risk Management

Situation Awareness

Create a World View

Situation Awareness

Create a World View

Gather information → Recognise and understands → Anticipate what will happen

Situation Awareness

Create a World View

Gather information

Recognise and understands

Anticipate what will happen

Level 1
Perception

Level 2
Comprehension

Level 3
Projection

Action

Decision

Based on Endsley

Talk about safer care

EWS rising

Family concerns

High Risk Meds

"Stable"

Communication issues

In "wrong" bed

Any potential harm

WATCHER

House Officer

Registrar and key staff

Outreach teams

Bedside nurse

Ward Manager

Safety team

Consultant

Table talk 8

Could you predict what can happen where you work?

Are we learning?

Ask what have we learnt?

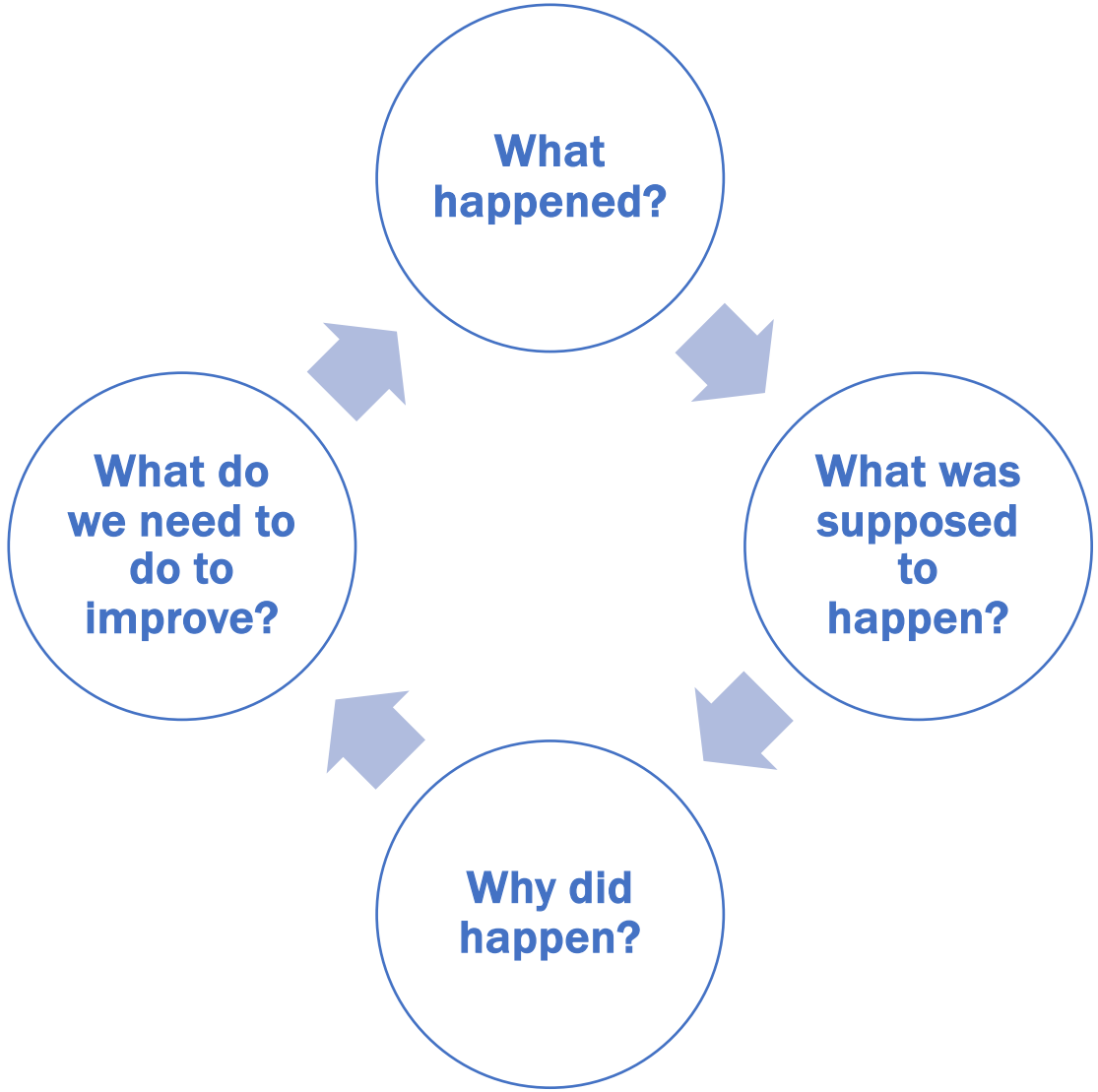


Table talk 9

What have you learnt today?

What will you do differently?

Summary

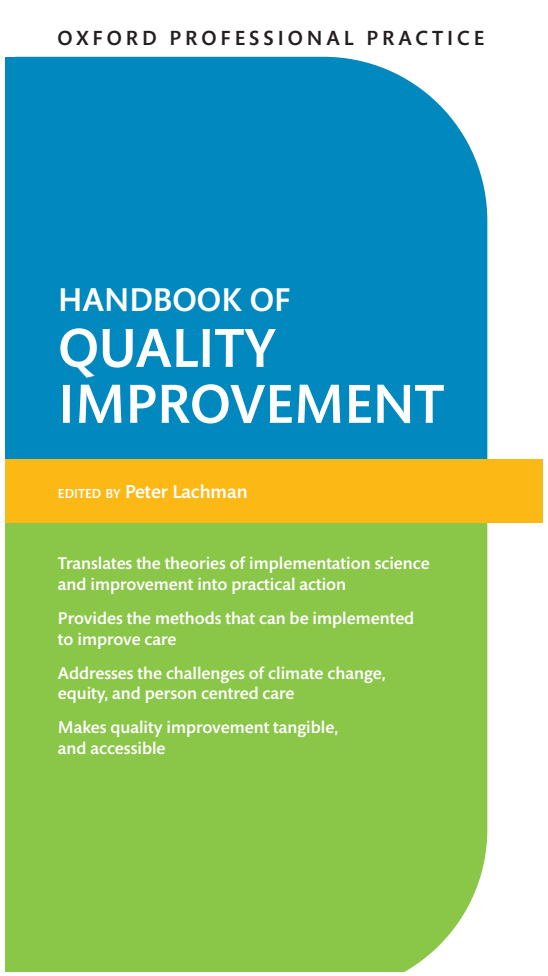
Think Differently
Lead for safety

Design for safety
Anticipation
Equity

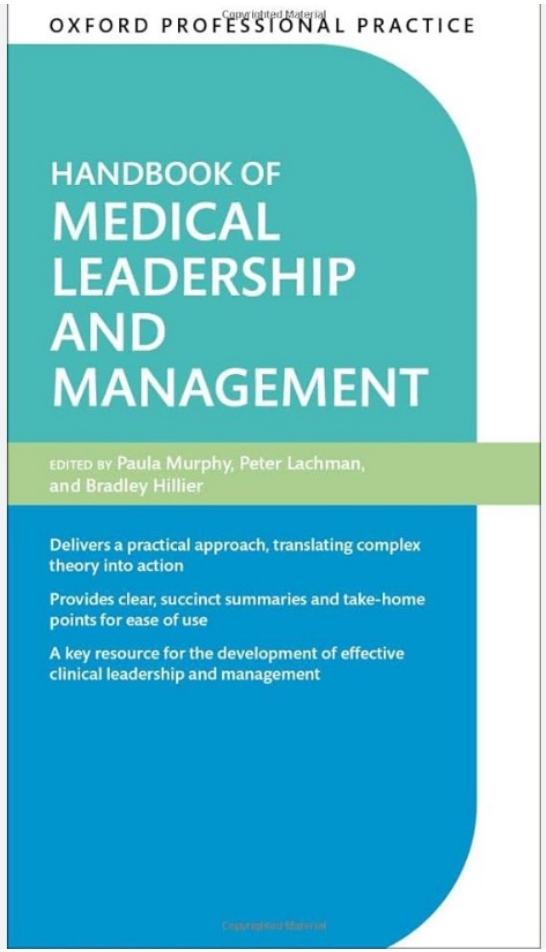
Lead for Safety
Measure

Coproduce
solutions

Learn


OXFORD PROFESSIONAL PRACTICE
HANDBOOK OF
QUALITY
IMPROVEMENT
EDITED BY Peter Lachman
Translates the theories of implementation science and improvement into practical action
Provides the methods that can be implemented to improve care
Addresses the challenges of climate change, equity, and person centred care
Makes quality improvement tangible, and accessible


OXFORD PROFESSIONAL PRACTICE
HANDBOOK OF
PATIENT
SAFETY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Delivers a practical approach, translating complex theory into action
Provides clear, succinct summaries and take-home points for ease of use
A key resource for the development of effective clinical leadership and management

Table talk 9

What have you learnt today?

What will you do differently?

HCAC2023
7TH QUALITY HEALTH CARE CONFERENCE AND EXHIBITION
Nov 13th-15th 2023

THANK YOU

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ROYAL COLLEGE OF PHYSICIANS OF IRELAND