Improvement Academy
Part of the Yorkshire & Humber AHSN

Workshop Outline for Training GP practices in Significant Event Audit.

NB deliver the presentations in order. Part 1, error theory; Part 2 SEA process; Part 3 QI for patient safety.

Part 1 Error theory minimum time to allow 1.5 hours

Time	Duration		Topic	objective	presenter	Resources
	5		Welcome Housekeeping	Mind set to learn and participate.		
	5		Introductions Objectives.	Start the dialogue early. Agree that it is easy to talk about errors if it's done in the right way.		Exercise. Have you made any mistakes getting here today?
	15		What is a patient safety incident?	Understand the terms Error, adverse event, patient safety incident, near miss etc.		Small groups or pairs with examples.
	10		Inevitability of error.	Appreciate epidemiology of error. Understand human error.		Colour/number test Selective perception test. (connection to YouTube required) Memory test
	15		Culture	Understand - punishment, perfection, person centered and systems approach. Consider second victim ideas. Incident decision tree.		Incident decision tree.
	15		Why things go wrong. A Human Factors Approach	Understand active failure and contributing factors and how this is depicted by Swiss Cheese. Appreciate that incidents have complex contributing factors. Understand the impact of Contributing factors.		Swiss cheese.
	25		Tour of YCCF	Understand the elements that make up the YCCF as related to general practice		YCCF hand out Group discussion of examples
	5		Close & Evaluations	Finish on time. Obtain feedback on session		Evaluation forms

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Part 2 SEA process - minimum time to allow 1 hour

Time	Duration		Topic	objective	presenter	Resources
	2		Welcome Housekeeping	Mind set to learn and participate.		
	3		Introductions Objectives.	Start the dialogue early. Agree that everyone has a contribution to make to SEA.		Exercise discuss the varying levels of involvement that people have had with significant event audit.
	10		SEA - Benefits	Appreciate SEA as a learning tool and the benefits of sharing lessons from incidents.		Small group or pairs discussion of the benefits – capture on flipchart
	20		SEA process	Understand how to conduct an SEA. Discuss who could do what. Re-confirm the need to concentrate on contributory factors		IA SEA Template. NPSA quickreference Guide. Exercise – Experience mapping a previous SEA.
	20		Worked example	Explore issues of conducting an SEA		Strictly Warfarin Hand-out Or Madopar incident with Commentary
	5		Close & Evaluations	Finish on time. Obtain feedback on session		Evaluation forms

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Part 3 Quality Improvement for safety - minimum time to allow 1 hour 45 mins

Time	Duration		Topic	objective	presenter	Resources
	2		Welcome Housekeeping	Mind set to learn and participate.		
	3		Introductions Objectives.	Start the dialogue early. Agree that not all change is change for the better		Exercise discuss past examples of changes that have been difficult to implement.
	30		Effective interventions	Understand which actions following SEA are likely to be the most and least successful.		Lee and Hirschler (stronger, moderately strong and weaker barriers) flash-cards
	15		IHI methodology	Understand that changes should be tested to and evaluated prior to 'wholesale change'		Link to Improvement Academy Quality Improvement Training
	20		SEA critique	Demonstrate ability to put SEA theory into context		SEA examples.
	10		NRLS – brief over view & Reporting SEA	Describe the potential and current limitations of NRLS. Promote NRLS reporting. Describe the CCGs approach to collecting SEA from GP practices		CCG to provide mechanism for practices to share completed SEA with the CCG
	10		Closing the loop	Sharing SEA and Feedback		CCG to provide Examples of local feedback mechanisms Link to IA website for Safety Snippets
	10		Action planning for trainers	Understand the expectations and support available. Attendees write action plans that describe how that / continue the will start.		
	5		Close & Evaluations	Finish on time. Obtain feedback on session		Evaluation forms