

Patient Safety Incident analyses

Giulia Dagliana

Coordinator WHO Collaborating Center in Human Factor and Ergonomics for the delivery of Safe and Quality Care of Center for Clinical Risk Mangment and Patient Safety, Tuscany Region





Who we are

Centre for Clinical Risk
Management and Patient Safety
founded in 2004 by the
Government to build a regional
system to promote patient safety
in all the healthcare local
authorities and hospitals in
Tuscany

Ergonomics and human factors approach as the drivers for a system change

The Chenter GRC has been appointed WHO Collaborating Center in Human Factor and Communoication for the delivery of Safe and Qulaity Care in 2016

- The regional public healthcare system accounts for 3.7 millions citizens
- 7 local healthcare trusts (32 community hospitals for acute cure), 4 university hospitals, in 3 wide geographic area
- 50.000 employees (18.000 nurses, 7000 physicians, 5000 administrative ecc.)
- 13.500 beds for 650.000 in-patients per year
- Highest scores in most of the national benchmarks on Q&S
- Health fund per year 6730M€





Who we are



Tommaso Bellandi

Director of the Quality and Safety Unit at the Tuscany Northwest Trust Safety and Quality Manager Ergonomist and human factor expert President of the Italian Ergonomic Society



Francesco Venneri

Emergency surgeon and physician
Clinical Risk Manager and Patient Safety Official of Florence Healthcare Service Secretary General of the Italian Network for Safety in Healthcare



Giulia Dagliana

Coordinator WHO
Collaborating Center
Safety and Quality
Manager
Ergonomist and human
factor expert
Expert in safety and
quality of care in lowresource settings





Outline

75minutes

Presentations by Tommaso & Francesco

- Human factor and ergonomics methods for conducting a structured analysis of PSI
- How to design and implement ameliorating actions
- Case studies: some example

60 minutes

Exercise in breakout rooms: analyses of a case studies

30 minutes

Sharing results of the analyses in plenary and wrap up







Enjoy your training!

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breakout rooms

Group 1 _moderator Francesco Venneri

Group 2_moderator Tommaso Bellandi

Group 1 case study on medication -related incident

Group 2_case study on surgical-related incident

You will receive the narrative of the safety incident and you should try to complete the fishbone diagram focusing on contributory factors

- 1) Reade carefully the narrative of the safety incidents
- 2) Discuss what may have contributed to the incident
- 3) Choose one among you in charge of filling out the diagram
- 4) Choose one among you in charge of reporting the results of the analyses during the plenary session



