Clin Pediatr 2017, 2:5(Suppl)
DOI: 10.4172/2572-0775-C1-006

Rethinking patient safety

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Healthcare is not different from any other high risk industry; people who are treated and cared for by the industry are also at risk of harm. The field of patient safety has grown out of this knowledge and seeks to figure out why harm happens and what we can do to minimize it as well as minimizing its effect. Over the last two decades in particular, significant efforts have been made to learn as much as we can about the system, the way in which human beings make errors and mistakes and how the system could be setup to help humans be safer. However, these efforts do not seem to have made many inroads and the same things are still happening now as they were over 20 years ago. We need to rethink patient safety. The talk would share key lessons from the presenters book Rethinking Patient Safety; lessons learnt from her experience in national patient safety policy and how a pediatric case study is being used to change the culture of the NHS from one of blame to that of learning and just. The audience will learn about the case of Richie William who died from inadvertent administration from intrathecal vincristine and how the way his death was investigated is helping people understand safety culture, human factors, human error and systems thinking. It will highlight the impact on clinicians when things go wrong, the need to share lessons internationally together with providing practical and simple ways in which we could transform the way in which we improve the safety of our patients by simply learning to talk and listen to each other more effectively.

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