CONCEPT

Healthcare Quality Improvement and Patient Safety: PDSA, Just Culture and RCA

12 – 16 April 2027
London - Central London four-star



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Ref: 291_12138 **Date:** 12 – 16 April 2027 **Location:** London - Central London four-star **Fees:** 23000 SAR

Introduction:

Healthcare quality improvement and patient safety efforts often stall on hospital wards: incidents go unreported for fear of blame, improvement projects start without measures, audit results sit in files and the same harm returns on another shift. This Core Concept course gives quality, nursing and clinical leaders a working method to govern quality, test changes with PDSA cycles, track clinical indicators on run charts, analyse adverse events and read safety culture survey results. Participants produce a Patient Safety and Quality Improvement Plan for a clinical unit in their own hospital.

Course Objectives:

- Set up clinical governance for quality and patient safety, with clear committee roles, reporting lines and a unit-level current-state assessment
- Run improvement projects with the Model for Improvement, PDSA cycles and Lean pathway mapping on real clinical processes
- Specify clinical indicators and plot them on run charts to judge whether a change has produced improvement
- Audit unit practice against the International Patient Safety Goals and turn gaps into prioritised actions
- Manage incident reporting, just culture decisions and root cause analysis of adverse events through to verified actions
- Interpret safety culture survey results and use data and AI tools to monitor quality and safety at unit level

Target Audience:

- Quality and performance improvement leads responsible for hospital improvement programmes and indicator reporting
- Patient safety leads responsible for incident reporting systems, adverse event reviews and safety committees
- Nursing leads responsible for ward standards, audits and bedside safety practice
- Clinical department heads accountable for the quality and safety results of their service
- Accreditation and clinical governance coordinators responsible for evidence, policies and survey readiness
- Infection prevention and clinical risk leads who join multidisciplinary improvement teams

Course Outline:

Day 1: Healthcare Quality, Patient Safety and Clinical Governance

- Patient Safety Definition and Preventable Harm Concepts as WHO States Them
- Quality Dimensions of Care: Safety, Effectiveness, Timeliness, Efficiency, Equity and Patient-Centredness
- Clinical Governance Structure: Quality Council, Patient Safety Committee and Unit Quality Leads
- Accreditation Readiness Overview: Standards Mapping, Evidence Files and Mock Surveys
- Clinical Unit Quality and Safety Current-State Assessment Checklist

Day 2: Improvement Methods in Hospitals: Model for Improvement, PDSA and Lean

- Model for Improvement: Three Fundamental Questions and Aim Statements for Clinical Teams
- Plan-Do-Study-Act Cycles for Small-Scale Tests of Change on a Ward
- Lean in Hospitals: Value Stream Mapping of a Patient Pathway and Waste Removal
- Driver Diagrams Linking Improvement Aims to Clinical Change Ideas
- Improvement Project Charter, Multidisciplinary Team Roles and Clinical Champions

Day 3: Measurement, Clinical Indicators and International Patient Safety Goals

- Outcome, Process and Balancing Measures for Clinical Improvement Projects
- Run Charts and Run Rules for Detecting Non-Random Change
- Clinical Indicator Specification: Numerator, Denominator, Exclusions and Data Source
- International Patient Safety Goals as Joint Commission International Lists Them
- Goal-Level Audit Tools: Patient Identification, Handover, High-Alert Medications, Safe Surgery, Infections and Falls

Day 4: Incident Reporting, Just Culture, RCA and Safety Culture Surveys

- Clinical Incident Reporting System Design: Near Misses, Adverse Events and Harm Grading
- Just Culture Principles for Non-Punitive Reporting and Clinical Staff Accountability
- Root Cause Analysis of Adverse Events: Timeline, Contributing Factors and Action Strength
- AHRQ Surveys on Patient Safety Culture SOPS: Hospital Survey Results Interpretation
- Data and AI Tools for Quality Monitoring: Indicator Dashboards and Incident Text Analysis at Overview

Day 5: Hospital Case Work and the Patient Safety and Quality Improvement Plan

- Case Study: Medication Error Report Taken Through Review, RCA and Action Plan
- Case Study: Inpatient Falls Run Chart and a Sequence of PDSA Tests
- Case Study: Safety Culture Survey Results Converted into Unit Action Priorities
- Patient Safety and Quality Improvement Plan Drafting with Indicator Baselines
- Quality Council Review Panel and Plan Defence

Skills You Will Gain:

- Clinical Governance Design
- PDSA Test Planning
- Hospital Pathway Mapping
- Run Chart Interpretation
- Clinical Indicator Specification
- Patient Safety Goal Auditing
- Adverse Event Root Cause Analysis
- Safety Culture Assessment

Why Attend This Course:

- Return with a Patient Safety and Quality Improvement Plan for a clinical unit in your own hospital, with indicator baselines
- Replace blame after incidents with a just culture response that keeps staff reporting and fixes system causes
- Show with run charts whether a change on the ward has worked, instead of relying on single audit results
- Compare improvement and safety practice with quality, nursing and clinical leaders from public, private and teaching hospitals

Conclusion:

Safer care comes from linking governance, improvement methods, measurement and learning from harm into one routine that clinical teams run every week. The course moves from quality dimensions and clinical governance, through the Model for Improvement, PDSA and Lean in hospitals, to run charts, clinical indicators and the International Patient Safety Goals, then to incident reporting, just culture, root cause analysis and safety culture surveys. The final day applies this to hospital cases and produces a Patient Safety and Quality Improvement Plan ready for review.