COURSE BROCHURE

Healthcare Quality and Patient Safety

An applied course in managing patient safety, from incident reporting and root cause analysis to building a safety culture and tracking clinical quality indicators.

Code	HT-HCM-102
Category	Healthcare & Hospital Management
Duration	1 week
Level	Intermediate

Introduction

Most errors that harm patients are not committed by careless individuals; they come from systems and procedures that let predictable human error reach the patient without a barrier in the way.

Objectives

- Explain the principles of safety science and the role of human factors in medical error
- Apply the International Patient Safety Goals to high-risk processes
- Run an incident reporting and learning system within a just culture
- Carry out a root cause analysis of a clinical event and propose strong actions
- Select quality and safety indicators and measure a unit's safety culture

Who should attend

- Quality and patient safety coordinators in hospitals and health centers
- Nursing heads and clinical unit supervisors
- Physicians serving on quality and peer review committees
- Clinical risk management officers

Skills you will develop

- Clinical incident analysis
- Applying just culture principles
- Designing clinical quality indicators
- Managing risk in high-risk processes

Learning Outcomes

- Classify a set of incident reports by type and level of harm
- Prepare a root cause analysis report for a clinical event with a timeline and contributory factors
- Select corrective actions using the hierarchy of action strength
- Prepare a quality and safety indicator card for a clinical unit

Course Outline

Day 1: Foundations of Patient Safety

- Dimensions of healthcare quality and WHO patient safety guidance
- Human factors and the Swiss cheese model of error

- Near misses, adverse events and sentinel events

Day 2: The International Patient Safety Goals

- Correct patient identification and effective handover communication
- High-alert medication safety and safe surgery
- Preventing falls and healthcare-associated infections

Day 3: Incident Reporting and Learning

- Designing a reporting system that is easy to use and non-punitive
- Classifying and triaging reports and deciding what needs investigation
- Just culture: telling human error apart from reckless behavior

Day 4: Root Cause Analysis in Healthcare

- Building the event timeline and interviewing the care team
- Analyzing contributory factors at patient, team and system level
- The action hierarchy, from training to system redesign

Day 5: Indicators and Safety Culture

- Structure, process and outcome indicators in clinical quality
- Measuring safety culture and leadership safety walkrounds
- Applied project: a patient safety improvement plan for the participant's unit, built on the analysis of an actual event

Training methodology

Analysis of anonymized incident reports drawn from typical hospital settings
Group workshop analyzing a serious clinical event from timeline to action plan
Applying a safety culture survey tool to participants' teams and discussing the results
Simulated safety walkround led by a participant in a fictional unit

Certification

Participants receive a Harbor Training Center certificate of attendance on completing the course.

Upcoming dates

City	Dates	Language	Fee
Istanbul	11 – 15 January 2027	AR	EUR 4,800
Dubai	18 – 22 January 2027	EN	EUR 4,500
London	25 – 29 January 2027	AR	EUR 5,700
Amsterdam	1 – 5 February 2027	EN	EUR 5,500
Online	8 – 12 February 2027	AR	EUR 1,800
Istanbul	12 – 16 July 2027	EN	EUR 4,800
Dubai	19 – 23 July 2027	AR	EUR 4,500
London	26 – 30 July 2027	EN	EUR 5,700
Amsterdam	2 – 6 August 2027	AR	EUR 5,500
Online	9 – 13 August 2027	EN	EUR 1,800

Fees are per participant.

Contact us

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To register and for details, scan the code or visit:

https://harbor4training.com/en/courses/healthcare-quality-patient-safety