<b>Course Title</b>	Quality & Safety Management		
Date &Time	Weekday evening night 18:30 – 21:30		
Description	This course introduces students to  (1) the concept, framework, practical approaches and current movement for safe, efficient, effective, and patient-centred healthcare;  (2) principle and practices of incident management and patient relations;  (3) concepts of errors in healthcare and principles and strategies in quality improvement		

I. Learning Content

Topic	<u>I.</u>	Learning Content	
Patient Safety & Safe culture     Risk management & Solutions  2. Risk management & Solutions  3. Incident management engagement and empowerment. Patient Relationship  5. Leadership & engagement of staff and patient for safe and quality healthcare  6. Principle of error  Principle of error  Patient control care patient engagement in healthcare: principle & approach (I)  8. Quality management in healthcare: practice (II)  Patient Safety & Safe culture  Perspectives for patient safety  Risk identification  Investigation / Root cause analysis  Risk reduction solution & programs  Incidents – definition, classification  Patient and family centred care  Patient participation, engagement, empowerment, share decision making, co-designing, co-production.  Patient relations issues  Leading change, implementation  Building capacity for patient safety  Staff engagement: why and how  Patient engagement: why and how  Patient engagement: why and how  Patient relations are principal for patient safety  Staff engagement: why and how  Patient rengagement  Building capacity for patient safety  Staff engagement: why and how  Patient relations of error  Paradigms of error and safety  Human factors and error  Panning  Defining quality  Approaches of quality management  PDCA cycle  Design principles Implementation  Defining result  Identifying solutions  Sources of influence  Evaluation  Finding the focus: reactive vs proactive  Determining whether change is required	Topic Contents/fundamental concepts		
Key elements of patient safety			Global and local movements on patient safety
Risk management & Solutions  2. Risk management & Solutions  3. Incident management engagement and empowerment. Patient Relationship  5. Leadership & engagement of staff and patient for safe and quality healthcare  6. Principle of error  9. Risk identification  1. Investigation / Root cause analysis  2. Risk reduction solution & programs  3. Incident management  4. Patient centred care, patient engagement and empowerment. Patient Relationship  5. Leadership & engagement of staff and patient for safe and quality healthcare  6. Principle of error  6. Principle of error  7. Quality management in healthcare: principle & approach (I)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  9. Patient redafinition, classification  9. Patient and family centred care  9. Patient and family centred care  9. Patient and family centred care  9. Patient relations in pagement why and how  9. Patient relations issues  9. Patient relations in pag	1. F	Potient Sofaty & Sofa culture	Perspectives for patient safety
Risk management & Solutions      Risk reduction solution & programs     Risk reduction solution & programs     Risk reduction solution & programs     Incident management     Patient centred care, patient engagement and empowerment. Patient Relationship  Leadership & engagement of staff and patient for safe and quality healthcare  Principle of error  Resk identification Investigation / Root cause analysis Risk reduction solution & programs Incidents — definition, classification Patient and family centred care Patient and family centred care Patient participation, engagement, empowerment, share decision making, co-designing, co-production. Patient relations issues Leading change, implementation Building capacity for patient safety Staff engagement: why and how Patient engagement of error Paradigms of error and safety Human factors and error Measures to reduce error Planning Defining quality Approaches of quality management PDCA cycle Design principles Implementation Defining result Identifying solutions Sources of influence Evaluation Finding the focus: reactive vs proactive Determining whether change is required Identifying where is change required		I attent Safety & Safe culture	Key elements of patient safety
2. Risk management & Solutions  a. Incident management  b. Patient centred care, patient engagement and empowerment. Patient Relationship  c. Leadership & engagement of staff and patient for safe and quality healthcare  b. Principle of error  c. Quality management in healthcare: principle & approach (I)  c. Quality management in healthcare: principle & practice (II)  c. Quality management in healthcare: principle & practice (II)  c. Risk reduction solution & programs  c. Incident — definition, classification  c. Patient and family centred care  patient participation, engagement, empowerment, share decision making, co-designing, co-production.  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation  Building capacity for patient safety Staff engagement: why and how  patient relations issues  c. Leading change, implementation  Building capacity for patient safety  Staff engagement: why and how  patient relations issues  c. Leading change, implementation  Building capacity for patient safety  Staff engagement: why and how  patient relations issues  c. Leading changement in patient safety  Staff engagement: why and how  patient relations issues  c. Leading changement in patient safety  Staff engagement: why and how  patient relations issues  Leading changem			Culture for safety.
<ul> <li>Risk reduction solution &amp; programs</li> <li>Incident management</li> <li>Incidents – definition, classification</li> <li>Immediate management</li> <li>Follow up actions</li> <li>Patient centred care, patient engagement and empowerment. Patient Relationship</li> <li>Leadership &amp; engagement of staff and patient for safe and quality healthcare</li> <li>Principle of error</li> <li>Principle of error</li> <li>Principle of error</li> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (II)</li> <li>Risk reduction solution &amp; programs</li> <li>Incidents – definition, classification</li> <li>Patient and family centred care</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement epatient of patient participation, engagem</li></ul>			Risk identification
<ul> <li>Incident management</li> <li>Incidents – definition, classification</li> <li>Immediate management</li> <li>Follow up actions</li> <li>Patient centred care, patient engagement and empowerment. Patient Relationship</li> <li>Leadership &amp; engagement of staff and patient for safe and quality healthcare</li> <li>Principle of error</li> <li>Principle of error</li> <li>Principle of error</li> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (II)</li> <li>Incidents – definition, classification</li> <li>Immediate management</li> <li>Follow up actions</li> <li>Patient and family centred care</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co</li></ul>	2.	Risk management & Solutions	Investigation / Root cause analysis
<ul> <li>Incident management  - Patient centred care, patient engagement and empowerment. Patient Relationship  - Leadership &amp; engagement of staff and patient for safe and quality healthcare  - Principle of error  - Quality management in healthcare:  - Patient management in healthcare:  - Principle &amp; approach (I)  - Rouality management in healthcare: principle &amp; practice (III)  - Patient centred care, patient engagement, empowerment, share decision making, co-designing, co-production.  - Patient and family centred care - Patient participation, engagement, empowerment, share decision making, co-designing, co-production Patient participation, engagement, empowerment, share decision making, co-designing, co-designing, co-production Patient participation, engagement, empowerment, share decision making, co-designing, co-production Patient relations issues - Leading change, implementation - Building capacity for patient safety - Staff engagement: why and how - Patient relations issues - Leading change, implementation - Building capacity for patient safety - Staff engagement: why and how - Patient relations sisues - Leading change, implementation - Building capacity for patient safety - Staff engagement: why and how - Patient relations issues - Leading change, implementation - Building capacity for patient safety - Staff engagement: why and how - Patient relations issues - Leading change, implementation - Building capacity for patient safety - Staff engagement: why and how - Definition and classification of error - Paradigms of error and safety - Patient relations issues - Leading change, implementation - Bui</li></ul>			Risk reduction solution & programs
<ul> <li>Follow up actions</li> <li>Patient centred care, patient engagement and empowerment. Patient Relationship</li> <li>Leadership &amp; engagement of staff and patient for safe and quality healthcare</li> <li>Principle of error</li> <li>Principle of error</li> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (III)</li> <li>Follow up actions</li> <li>Patient and family centred care</li> <li>Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>Patient relations issues</li> <li>Leading change, implementation</li> <li>Building capacity for patient safety</li> <li>Staff engagement: why and how</li> <li>Definition and classification of error</li> <li>Paradigms of error and safety</li> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			• Incidents – definition, classification
<ul> <li>4. Patient centred care, patient engagement and empowerment. Patient Relationship</li> <li>5. Leadership &amp; engagement of staff and patient for safe and quality healthcare</li> <li>6. Principle of error</li> <li>7. Quality management in healthcare: principle &amp; approach (I)</li> <li>8. Quality management in healthcare: principle &amp; practice (II)</li> <li>8. Quality management in healthcare: principle &amp; practice (II)</li> <li>9. Patient and family centred care</li> <li>9. Patient participation, engagement, empowerment, share decision making, co-designing, co-production.</li> <li>9. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Building capacity for patient safety</li> <li>9. Staff engagement: why and how</li> <li>9. Definition and classification of error</li> <li>9. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Definition and classification of error</li> <li>1. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Definition and classification of error</li> <li>1. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Building capacity for patient safety</li> <li>9. Staff engagement: why and how</li> <li>9. Definition and classification of error</li> <li>1. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Definition and classification of error</li> <li>1. Patient relations issues</li> <li>1. Leading change, implementation</li> <li>9. Building capacity for patient safety</li> <li>1. Staff engagement: why and how</li> <li>1. Definition and classification of error</li> <li>1. Patient nations</li> <li>1. Definition and classification of error</li> <li>1. Patient nations</li> <li>2. Definition and classification of error</li> <li>3. Patient nations</li> <li>4. Definition and classification of error</li> <li>5. Def</li></ul>	3.	Incident management	Immediate management
engagement and empowerment. Patient Relationship  5. Leadership & engagement of staff and patient for safe and quality healthcare  6. Principle of error  6. Principle of error  Patient relations issues  • Leading change, implementation • Building capacity for patient safety • Staff engagement: why and how • Patient engagement: why and how • Patient engagement: why and how • Paradigms of error and safety • Human factors and error • Measures to reduce error  Planning • Defining quality • Approaches of quality management • PDCA cycle • Design principles Implementation • Defining result • Identifying solutions • Sources of influence Evaluation • Finding the focus: reactive vs proactive • Determining whether change is required		-	Follow up actions
empowerment. Patient Relationship  5. Leadership & engagement of staff and patient for safe and quality healthcare  6. Principle of error  6. Principle of error  6. Principle was approach (I)  7. Quality management in healthcare: principle & approach (I)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  8. Quality management in healthcare: principle & practice (II)  9. Defining quality  9. Defining quality  9. Defining quality  9. Defining quality  9. Defining result  9. Defining result  9. Defining result  9. Identifying solutions  9. Sources of influence  Evaluation  9. Finding the focus: reactive vs proactive  9. Determining whether change is required	4.	Patient centred care, patient	Patient and family centred care
Patient Relationship  Definition and classification of error  Principle of error  Principle & approach (I)  Quality management in healthcare: principle & approach (I)  Quality management in healthcare: principle & practice (II)  Patient relations issues  Leading change, implementation  Building capacity for patient safety  Staff engagement: why and how  Patient engagement engagement engagement  Patient engagement engagement  Patient engagement  Patient engag		engagement and	• Patient participation, engagement, empowerment, share
5. Leadership & engagement of staff and patient for safe and quality healthcare  • Leading change, implementation • Building capacity for patient safety • Staff engagement: why and how • Patient engagement: why and how • Patient engagement: why and how • Paradigms of error and safety • Human factors and error • Measures to reduce error  Planning • Defining quality • Approaches of quality management • PDCA cycle • Design principles Implementation • Defining result • Identifying solutions • Sources of influence Evaluation • Finding the focus: reactive vs proactive • Determining whether change is required • Identifying where is change required			decision making, co-designing, co-production.
<ul> <li>Building capacity for patient safety</li> <li>Staff and patient for safe and quality healthcare</li> <li>Building capacity for patient safety</li> <li>Staff engagement: why and how</li> <li>Patient engagement: why and how</li> <li>Definition and classification of error</li> <li>Paradigms of error and safety</li> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>		Patient Relationship	Patient relations issues
<ul> <li>staff and patient for safe and quality healthcare</li> <li>Staff engagement: why and how</li> <li>Patient engagement: why and how</li> <li>Definition and classification of error</li> <li>Paradigms of error and safety</li> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>	S	Landarchin & angagament of	Leading change, implementation
quality healthcare  Patient engagement: why and how  Definition and classification of error  Paradigms of error and safety Human factors and error Measures to reduce error  Planning Defining quality Approaches of quality management PDCA cycle Design principles Implementation Defining result  Identifying solutions Sources of influence Evaluation Finding the focus: reactive vs proactive Determining whether change is required Identifying where is change required		staff and patient for safe and	Building capacity for patient safety
<ul> <li>Patient engagement: why and how</li> <li>Definition and classification of error</li> <li>Paradigms of error and safety</li> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			Staff engagement: why and how
<ul> <li>Principle of error</li> <li>Paradigms of error and safety</li> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>		quanty nearmoure	
<ul> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>		Principle of error	Definition and classification of error
<ul> <li>Human factors and error</li> <li>Measures to reduce error</li> <li>Planning</li> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>	6		
Planning  Defining quality  Approaches of quality management  PDCA cycle  Design principles  Implementation  Defining result  Identifying solutions  Sources of influence  Evaluation  Finding the focus: reactive vs proactive  Determining whether change is required  Identifying where is change required	0.		Human factors and error
<ul> <li>Defining quality</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			Measures to reduce error
<ul> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (II)</li> <li>Approaches of quality management</li> <li>PDCA cycle</li> <li>Design principles</li> <li>Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence</li> <li>Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			Planning
<ul> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (II)</li> <li>PDCA cycle  • Design principles  Implementation  • Defining result  • Identifying solutions  • Sources of influence  Evaluation  • Finding the focus: reactive vs proactive  • Determining whether change is required  • Identifying where is change required</li> </ul>			9 5 7
<ul> <li>Quality management in healthcare: principle &amp; approach (I)</li> <li>Quality management in healthcare: principle &amp; practice (II)</li> <li>Design principles Implementation</li> <li>Defining result</li> <li>Identifying solutions</li> <li>Sources of influence Evaluation</li> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			
healthcare: principle & approach (I)  8. Quality management in healthcare: principle & practice (II)  • Design principles Implementation • Defining result • Identifying solutions • Sources of influence Evaluation • Finding the focus: reactive vs proactive • Determining whether change is required • Identifying where is change required	7	healthcare:	PDCA cycle
principle & approach (I)  8. Quality management in healthcare: principle & practice (II)  8. Practice (II)  Implementation  Defining result  Identifying solutions  Sources of influence Evaluation  Finding the focus: reactive vs proactive  Determining whether change is required  Identifying where is change required	/.		
<ul> <li>8. Quality management in healthcare: principle &amp; practice (II)</li> <li>• Identifying solutions</li> <li>• Sources of influence</li> <li>Evaluation</li> <li>• Finding the focus: reactive vs proactive</li> <li>• Determining whether change is required</li> <li>• Identifying where is change required</li> </ul>			
<ul> <li>Sources of influence</li></ul>			
healthcare: principle & practice (II)  • Sources of influence Evaluation • Finding the focus: reactive vs proactive • Determining whether change is required • Identifying where is change required	8.	healthcare: principle &	
practice (II)  • Finding the focus: reactive vs proactive  • Determining whether change is required  • Identifying where is change required			
<ul> <li>Finding the focus: reactive vs proactive</li> <li>Determining whether change is required</li> <li>Identifying where is change required</li> </ul>			
Identifying where is change required		1 ()	_
Improve vs Control			, , ,
1			Improve vs Control

9. Student Presentation	Case Study
-------------------------	------------

## **II.** Learning Outcomes or Objectives of the course

Student should be able to:

- 1a. Understand the discipline of risk management, patient safety and patient relations
- 1b. Apply the concept and approach to
  - (i) identify and manage clinical risks,
  - (ii) manage adverse event,
  - (iii) enhance patient-engagement and relations, and
  - (iv) lead change (in quality and safety).
- 2a. Apply concepts of errors in healthcare improvements.
- 2b. Apply principles, tools, evaluation strategies and documentation method in quality improvement

Face-to-face lectures will be resumed as normal teaching format in 2021/22 academic year.