

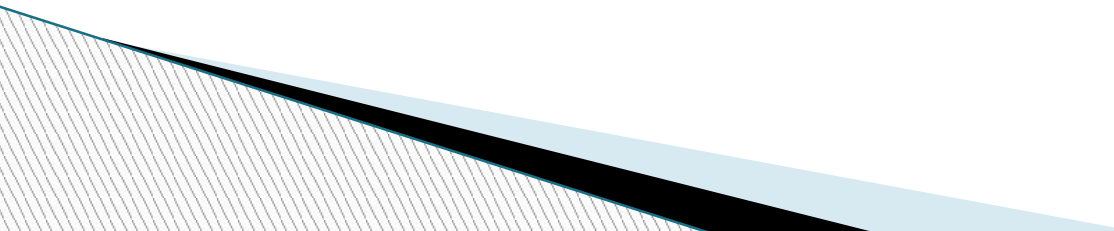
A large teal triangle graphic pointing downwards, positioned on the left side of the slide.

# Threats and errors

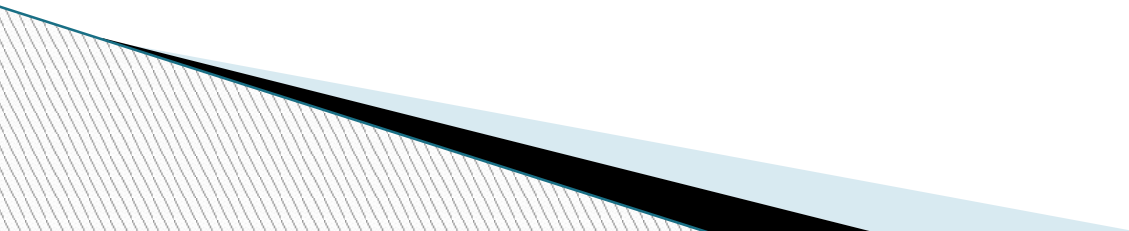
How a “never event” happened

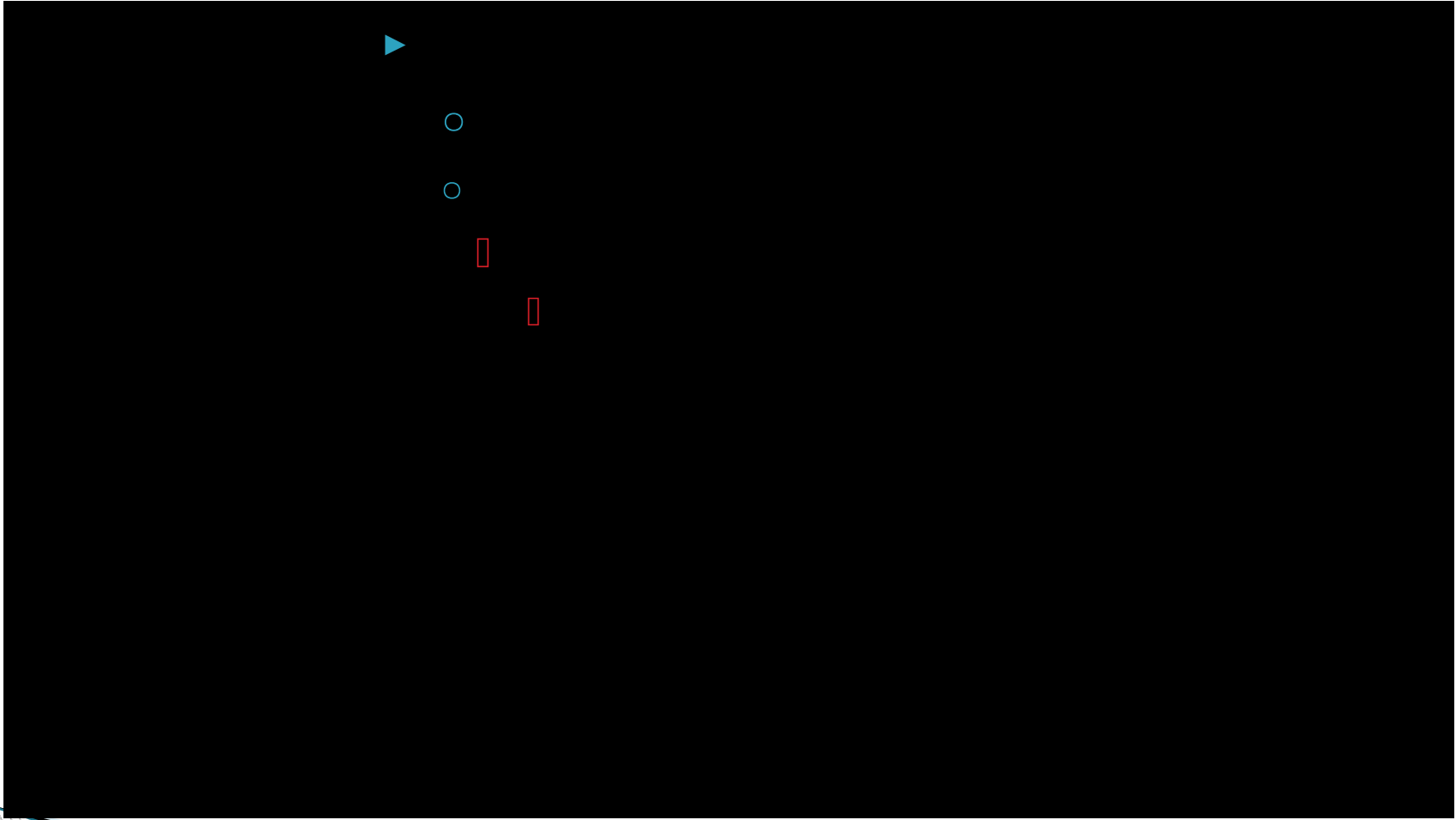
Decorative background elements at the bottom of the slide, including a light blue gradient bar, a black horizontal line, and a white area with fine diagonal hatching.

# Objectives

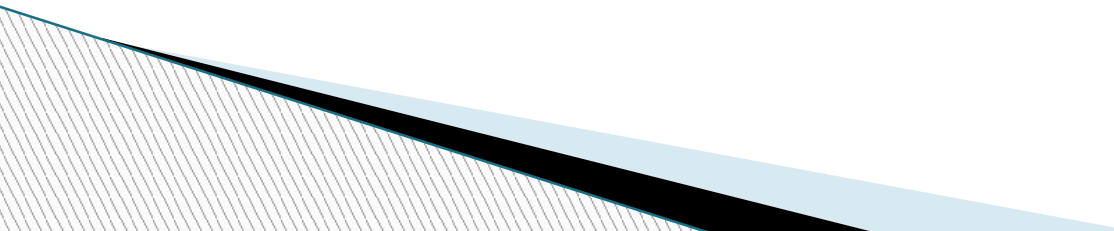
- ▶ Why do mistakes occur?
  - ▶ Review how failures can be identified by root cause analysis
  - ▶ Plan what could be done to prevent this happening again
  - ▶ Highlight the importance of a culture of safety in any organisation
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# Threats and errors

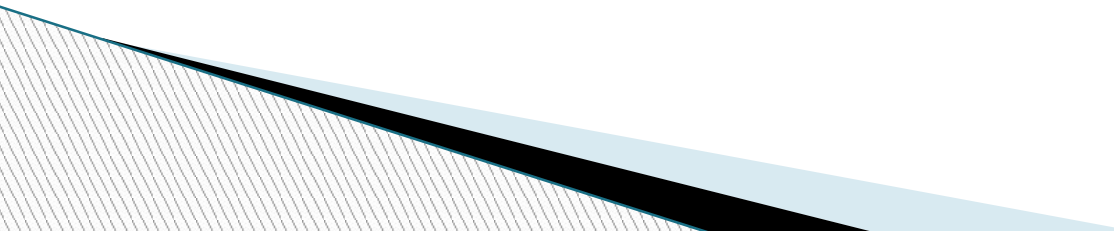


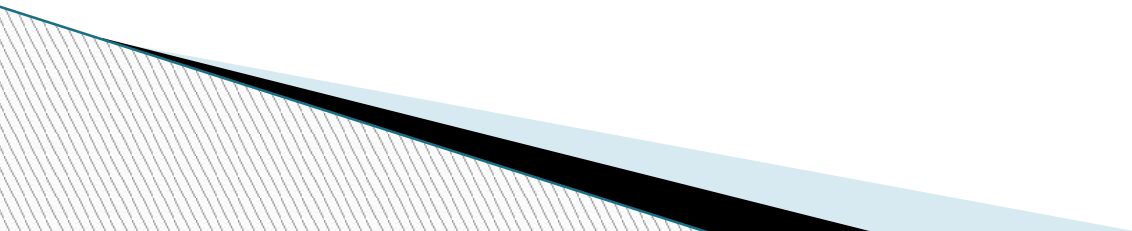


# Case study

- ▶ Where are the problems?
  - ▶ What types of threat are there?
  - ▶ What types of error are there?
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# Threats and errors identified

- ▶ Why did they arise in the first place?
  - ▶ Contributory factors
  - ▶ What would you do?
  - ▶ The culture of the organisation
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# Review

- ▶ Origin of mistakes in healthcare
  - ▶ Root cause analysis
  - ▶ Develop action plans
  - ▶ Culture of safety
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