3. Empowerment

In what ways could I protect patient safety by alerting colleagues regarding my concern for their lack of appropriate skill, knowledge or attitude?

Some of the highest profile errors have resulted in professionals 'inability to challenge colleagues'. This remains a difficult area. Recent articles have highlighted that error is not necessarily a sign of professional inability. Error does not always equal negligence. We hope to challenge historical concerns of a 'blame culture'.

This workshop will look at tools to help you speak out effectively and within your profession and examine how to speak with patients and their families about mistakes.

How to report an incident:
This takes two main forms.

1. Informing your line manager of any incident or near miss.

2. Complete a clinical incident form (Appendix C), page 30.
A  Ask  “Is that the correct drug/dose.”
L  Listen  “I think so, I didn’t draw it up”
E  Ensure patient safety  “I don’t think we should give this drug”
R  React  “Dispose of unlabelled drug”
T  Take Help (Reflect)  “Ask senior, administer correct drug and dose”

You should be able to:
Define Clinical Governance:

Define audit:

Explain Consent:

Who can you call for help?

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<thead>
<tr>
<th>Profession</th>
<th>Authority/ Professional regulatory body</th>
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<tr>
<td>Doctors/Medical Students</td>
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<td>Nursing and Midwifery</td>
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<td>Therapists and allied professions</td>
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<td>Pharmacists</td>
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