

Patient Safety Tools Training: Root Cause Analysis

Health care facilities spend considerable time improving processes and yet untoward events still happen. Why? Because often process changes are not directed at the latent conditions that are setting people up to make mistakes. In this workshop you'll learn how to determine if the fundamental system deficiencies that precipitated an untoward event have been found and how to develop sustainable corrective actions to prevent similar incidents in the future. You'll also discover why traditional process improvements have failed to eliminate the risk of untoward events and what safeguards are needed to prevent simple errors from causing accidents.

Learning Objectives

- Identify the purpose of various investigations that might occur following a sentinel event or significant adverse incident.
- Describe elements of a "thorough" root cause analysis and what is often missing from investigations.
- Apply analytical tools that help caregivers identify the event's root causes and latent conditions.
- Discover how to determine if the root causes and latent conditions that precipitated the adverse event have been found.
- Identify strategies for developing effective corrective actions and follow-up monitoring activities.

Agenda

Root Cause Analysis Overview

- Difference between root cause analysis, peer review, and risk management incident investigations.
- Interface of root cause analysis with organization-wide performance improvement activities.
- Organizational policies, procedures and oversight.
- Selecting events for a root cause analysis

Steps of a Thorough Root Cause Analysis

- How to use analytical tools that are more powerful than the Joint Commission's RCA model to identify root causes and latent failures.
- How to determine if the fundamental system deficiencies that precipitated the adverse event have been found.

Improvement Actions: The Most Important Step of the RCA

- Why action plans often fail to achieve desired results.
- Selecting actions that will reduce the likelihood of mistakes throughout the organization.
- Simple strategies for monitoring the effectiveness of actions.
- How to keep the organizational climate from side-tracking your RCA efforts

Who Should Attend: Patient Safety Coordinators, Quality and Performance Improvement Professionals, Risk Managers and others who have responsibility for facilitation of Root Cause Analysis

Faculty

Patrice L. Spath, Principal, Brown-Spath & Associates, Forest Grove, Oregon

Ms Spath is a widely sought after trainer and consultant whose advice is innovative, up-to-date, and immediately applicable to your unique environment. During the past 25 years, she has presented over 350 educational programs on healthcare quality and patient safety topics. Since 2005 she has facilitated workshops sponsored by the Maryland Patient Safety Center. She has authored several books and over 150 journal articles on these topics for the American Hospital Association, Health Administration Press, Jossey-Bass, Brown-Spath & Associates, and other publishers.





*Making Maryland's Healthcare
the Safest in the Nation*

Root Cause Analysis

Registration 8:00 AM, Program 8:30 AM – 3:30 PM

Wednesday, March 21, 2012

MHEI Conference Center, Elkridge, MD

*Your registration is not complete until you receive a confirmation from the
Program Coordinator*

[CLICK HERE TO REGISTER ONLINE](#)

Program Fee: \$49

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